

'THE BUSINESS END': PERSPECTIVES ON MENTAL DISTRESS IN THE CONTEXT
OF NEOLIBERAL RESTRUCTURING OF COMMUNITY MENTAL HEALTH SERVICES

by

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A thesis submitted to the University of Birmingham for the degree of DOCTOR OF
PHILOSOPHY

Institute of Applied Social Studies

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August 2013

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ABSTRACT

Contemporary neoliberal reconfigurations of statutory mental health services involve significant organisational changes. Based on findings from twelve months fieldwork within a community mental health team, the thesis examines the effects of this new service landscape on the way conceptualisations of mental distress are utilised and articulated.

The thesis combines critical realist epistemology and reflexive ethnographic method to produce a contextually situated understanding of the field capturing the dynamic relationships between concepts, agents and the context of action. This draws on and extends Rhodes' 'pentimento' (1993) as a conceptual framework for understanding mental health practice. It argues the mental health team is a 'differentially sedimented structural institution' in which practitioners and service users navigate a field of contradictions defined by four strata: the custodial system of the asylum; the biomedical treatment system of the hospital; community care within the Keynesian welfare state; and neoliberal welfare reconfigurations. These are conceptualised as ideological positions that co-exist within practitioners as alternative modes of thinking and operate in a relationship of mutual tension. Practice should be understood as a process shaped by mechanisms at different levels of scale from micro to macro, and involving movement between these overlapping and co-existing strata of historically sedimented meaning.

ACKNOWLEDGEMENTS

I would like to start by offering my sincerest thanks to the practitioners, service users and carers at Southville and Northville CMHTs for their generosity in giving that most precious of resources (and one that is in such short supply at CMHTs!) – time, and for making me feel welcome. I am deeply grateful to them for that support.

I must also acknowledge an enormous debt of gratitude to my supervisors. To Ann Davis, not only for seeing the potential in the study and playing a crucial role in accessing the funding through CEIMH to enable it to happen, but also for offering encouragement, support and sage advice - both personal and intellectual - during the early stages. To Jerry Tew for providing expert guidance, patience and continuity throughout the five years. And to Sue White for a theoretical acuity and ethnographer's eye that was extremely valuable during the write up phase (and for supervising the PhD for a year longer than anticipated!) I must also acknowledge the essential role played by ESRC studentship funding.

Thanks too to Jonathan Neale and Nancy Lindisfarne, dear friends and comrades, always encouraging, inspiring and critical (in the best possible way!) I'm sure the idea of doing a PhD would never have occurred to me without their encouragement.

I am similarly grateful to Michael Lavalette, Iain Ferguson and colleagues in SWAN for the debates, discussion and activism that have assisted my thinking around the effects of neoliberalism on public services; and Michael (again) for enabling the space from my work duties to finish the thesis.

I also appreciate the flexibility and understanding shown by my colleagues at Liverpool Hope University while I've been away from my desk completing the study (and thanks to Joe Greener in particular for technical support!)

A couple of other expressions of gratitude are necessary. To Roy Bhaskar for generously offering time to feedback on drafts of parts of the methodology chapter, and to the late Geoff Pearson for input at Goldsmiths at a very early stage of this project.

Finally, enormous thanks to my family but in particular George Williams, Grandad, for being there when it mattered and encouraging me to read books all those years ago!

And last but not least to my partner Nicola Doherty – for love, care, forbearance, tolerating my seemingly endless weekends spent in the library and unwavering support over the five long years of the study, through all the ups and downs. Thank you with all my heart.

ABBREVIATIONS

CBT – Cognitive Behavioural Therapy

CMHN - Community Mental Health Nurse

CMHT - Community Mental Health Team

CPA - Care Programme Approach

CQUIN - Commissioning for Quality and Innovation

CR – Critical Realism

CRT – Crisis Resolution Team

DSM - The Diagnostic and Statistical Manual of Mental Disorders

DH - Department of Health

FT – NHS Foundation Trust

HoNOS – Health of the Nation Outcome Scales

ICD - The International Classification of Diseases

NHS - National Health Service

OT – Occupational Therapist

RiO – Electronic Case Record system

SSD - Social Services Department

ST5 – Specialty Registrar (Psychiatrist)

PbR – Payment by Results

SpR – Specialist Registrar (Psychiatry)

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1. INTRODUCTION

1.0 Overview

Integrated multi-disciplinary community mental health teams (CMHTs), where practitioners from a number of occupations work together, are a central element of the organisation of contemporary mental health services. The challenges of such structures for professional practice have been well documented. However, the way in which these processes intersect with the competing models of mental distress¹ utilised by the various practitioner groups and service users has been less thoroughly researched. Moreover, the context of mental health practice is rapidly shifting with a number of recent reforms to services including the promotion of the recovery model, increased service user involvement, changing professional roles and greater performance management and marketisation (Lester and Glasby, 2006). The aim of my study, therefore, is to develop a more contemporary situated understanding of the impact of restructuring of the mental health field on the articulation and negotiation of these frameworks.

In order to address this topic I have employed an ethnographic methodology to provide a contextual understanding of the lived experience of practitioners, service

¹ There are a number of amalgam terms used to describe the experiences labeled as 'mental illness'. I will primarily utilise 'mental distress' in this thesis, reflecting my disciplinary background and value position. Where it reflects the terminology articulated by particular authors or practitioners I will use others such as mental illness or mental disorder. However it should be noted that any of these terms can be challenged for their descriptive and explanatory adequacy.

users and carers. The ethnographic method has a significant tradition in health care environments (Goffman, 1961; Rhodes, 1991). However, whilst these and other ethnographic studies have deepened our understanding of these fields, they are positioned within the constructivist or interpretivist paradigms which have been criticised for their failure to acknowledge sufficiently the structural context and the impact of power relations (Callinicos, 1987). Critical realism has been proposed as a means of addressing such epistemological limitations. This study has therefore aligned itself within an emerging methodological approach that combines reflexive ethnography with a critical realist epistemology (Davies, 2008).

1.1 Background to the study

The initial conception for this study arose out of an interaction between aspects of my occupational and personal biography and has been informed by the political and ethical stances to which I am committed. My experience as a social care practitioner and, later, social worker provided a context within which certain ‘foreshadowed problems’² emerged (Hammersley & Atkinson, 2007). My wish to explore and better understand these issues subsequently provided both the impetus to embark on doctoral research and an orientation for this research project. I will therefore begin by providing some background to my interest in this topic area. I hope that this will offer

² The anthropologist Malinowski, who played a key role in the development of the ethnographic fieldwork method, coined this term to describe a process whereby ethnographers frequently develop studies of the lives and perspectives of others from a relatively open-ended interest in a particular facet of social experience.

the reader relevant contextual information, and demonstrate my commitment to a reflexive ethnographic stance in this thesis (Davies, 2008).

I began my career as the community care policy framework was reshaping services in the UK during the early 1990s. I worked initially in services with learning disabled adults, and witnessed de-institutionalisation entering its final stages with the long awaited closure of large asylums. My first job involved residential support to profoundly disabled service users who had relocated from a hospital officially named Coldeast located just beyond the rolling green hills of the South Downs but informally referred to as 'Colditz' by some former 'patients' and staff critical of its prison-like conditions. In the community residential services for which I worked, and into which these service users moved, new forms of practice were defined via concepts such as normalisation and the social model of disability. These new services and our practice were far from de-medicalised or service-user led. However, both moved towards greater recognition of the role of the social environment, and provided a context that was much more conducive to our attempts to support user self-determination and both individual and collective rights than the institutionalised conditions on the wards from which people had relocated. Moreover it seemed to me that, in order to realise a high standard of support for this marginalised group of service users, it was essential to recognise the necessity of decent conditions of service for staff. For this reason I engaged in trade union work alongside my practice role. I considered both to be an expression of my value orientation towards social justice³.

³ The work of Fulford (2008) on values-based practice has usefully highlighted the complex and sometimes conflicted relationship between knowledge and values within the mental health field. There is further discussion of values-based practice in Chapter 3.

Having completed several years working in a range of settings with this service user group, I felt drawn to the challenge of higher education. Wishing to combine my concern for issues of social justice with an interest in the experience of the poor and marginalised communities in India, where I had travelled extensively, I registered for a degree in South Asian Politics and Culture. A particular focus for my dissertation was the neo-liberal market reform⁴ of the Indian economy and society in the early 1990s, and its relationship to the emergence of authoritarian and discriminatory movements against the poor and minority communities on the sub-continent. Moreover this was the setting for my first educational encounter with social anthropology. I was particularly impressed with the utility of its primary method, ethnography, as a means for developing holistic understandings of forms of social and cultural organisation, and this undoubtedly influenced my choice of methodology for the current study.

Throughout the course economic necessity determined that I continue to work in the social care field one day per week in a role supporting learning disabled service users with additional mental health needs. On graduation I was offered a full-time role by this third sector employer and returned to social care practice. Having considered the effects of neoliberalism in India in such great detail, their impact on the health and social care field was, perhaps, more vividly recognisable to me in my day-to-day work. Continued trade union and socialist activism was one way in which I was able to challenge and critique these processes. Whilst I enjoyed my work I

⁴ See, for instance, Vanaik (1990). The concept of neoliberalism will be discussed further in Chapter 3.

increasingly recognised the need for a fresh challenge and decided that professional training would offer the opportunity to develop my practice skills. And so, when finances eventually permitted, I enrolled on a course in social work. On reflection my aspiration in applying was not only to improve as a practitioner and ultimately access professional employment but also to have an opportunity, as a post-graduate student, to engage in further research.

Having completed the course I gained a social work post within statutory mental health services. However, while I had become aware of some of the ideological contrasts within learning disability and mental health services when working in the third sector, my experience of practice in the statutory sector brought this into much sharper focus. During the final year of my training whilst on six-month placement within a statutory community mental health team I had been disappointed to find a significantly different theoretical and value base orientation to that of the learning disability field. Though I worked alongside committed and sensitive practitioners from a range of occupational groups broadly comparable to those in learning disability services and within a policy context similarly foregrounding de-institutionalisation and community care reforms, 'medical model' approaches⁵ remained predominant. It seemed that social factors, while recognised to some degree, were reduced to a subsidiary status with the use of psychotropic medication virtually ubiquitous. This

⁵ The 'medical model', as frequently articulated, tends to be a somewhat amorphous attribution. Pilgrim et al. (2008) trace the emergence of this concept to professional psychiatry's mid-nineteenth century project to achieve pre-eminence over 'mental disorder' and identify three strands: administrative jurisdiction over madness, biological causation and a eugenic consensus about mental abnormality. However it should be noted that critics of bio-reductionism, for instance Engel (1977) who developed the biopsychosocial model, have nonetheless retained the term 'medical model' for their alternative orientation.

was also the case, perhaps even more so, in the Crisis Resolution Team within which I subsequently worked as a practitioner. The tensions here between an evolving policy rhetoric promoting social inclusion and the emphasis in practice on medication and organisational targets were intense.

It was thus that the foreshadowed problem for the research study crystallised, rooted in a desire to better understand these tensions and contrasts and the circumstances and processes underpinning them. However, as an activist, this desire goes beyond a wish simply to enhance our knowledge of this issue, crucial though that may be. As Marx famously said, 'philosophers have only interpreted the world, the point is to change it' (Marx, 2002), and as such this study also aspires to make its own small contribution to the promotion of a mental health practice that is guided by holistic conceptions of the person and values of social justice, and that places mental distress within its wider social context.

1.2 Research questions

The broad aims of the thesis are to explore how differing professional conceptualisations of mental distress are expressed and negotiated in CMHTs, and how social perspectives may or may not be articulated within this. The overall aim of the research has four key dimensions:

- To identify which theoretical models of mental distress inform professional practice in community mental health teams.

- To explore how articulation of these models relates to their contextual situation within environments shaped by occupational, organisational, policy and wider socio-economic processes and the relative power relationships arising from these.
- To examine the implications of these processes for social perspectives within mental health practice, and the impact on the experiences of service users, carers and frontline practitioners.
- To contribute to an emerging methodological approach that combines reflexive ethnography with a critical realist epistemology.

The suitability of an ethnographic method was established via the conduct of a pilot study (Moth, 2008a) that sought to explore the particular challenges of conducting an ethnographic study from a 'peripheral membership role' as researcher rather than as a practitioner (Adler and Adler, 1987). My particular focus during this pilot stage was identity in the field, access and power relations, and the impact of these upon data collection. The pilot study also indicated a need for inclusion of supplementary methods to further strengthen the methodology. Therefore, in addition to twelve months of participant observation, the final stage of data collection involved two supplementary methods: in-depth interviews with practitioners, service users and carers, and analysis of care plans and assessments.

1.3 Thesis structure

The final section of this introductory chapter will provide an overview of the contents of the thesis. Before this, however, it should be noted that throughout the period in which the study was conducted a number of significant shifts in mental health policy and practice have taken place. Whilst it is important to recognise their effects, it is also necessary to set realistic parameters for the discussion. For this reason consideration will only be given to policy reforms up until the end of 2012.

The thesis is organised into three sections. In chapters 2-3 an overview of the relevant research and policy literature is provided; Chapters 4-5 detail the theoretical and methodological orientation of the study; in Chapters 6-9 the findings are presented in the form of two case studies, a third chapter that provides an overview of practice within the CMHT studied, and a fourth that draws together the analytical implications of the three previous chapters. Finally Chapter 10 summarises implications for practice and further research and reflects on the methodology utilised. The content of each of these chapters will now be outlined in greater detail.

In the first section consideration of the literature is separated into two key areas: concepts utilised by practitioners and service users, and the practice and policy context that shapes the nature of mental health service activity. In Chapter 2 the various ways of conceptualising and categorising the experience of mental distress are outlined. This includes biomedical and psychological models, lay perspectives, forms of social and sociological knowledge and 'modern' social models that draw on

developments in the disabled people's and mental health service user/survivor⁶ movements. Having presented some of the dominant ways of conceptualising mental distress, the next chapter will provide an overview of the institutional and policy context of practice.

Chapter 3 comprises four sections and these elaborate the most significant historical and institutional factors that shape the practice of mental health workers and those who are the recipients of their services. In the first section the nature of professionalism and the mental health labour process are outlined. It is argued that sociological understandings of the professions such as those of trait and market strategist theorists cannot provide a satisfactory account of the activity of occupational groups as services are reshaped over time by neoliberal managerialist reforms. A more compelling account is provided by labour process theory that incorporates analysis of the increasing routinisation and fragmentation of professional work and an escalating culture of audit and administrative control in the context of neoliberal managerialism and the marketisation of mental health services. Three other significant and related dimensions of the contemporary reconfiguration of mental health practice are also discussed. The first is the integration of occupational groups within inter-professional teams. Second is the growth of the structural influence of patients and service users, a contradictory and ambiguous process resulting from the development of user/survivor movements on the one hand and the promotion of individual consumerism in public services on the other. The third is the emergence of risk as a central pre-occupation for policy and practice, moulding

⁶ The terminology used to describe those who use mental health services is contested. In this thesis the term service user will be used, but also survivor when referring to mental health movements.

assessment and resource allocation processes and resulting in 'structural stigma' and coercive forms of intervention.

Overall, chapters 2 and 3 outline, respectively, the predominant ways of conceiving knowledge in mental health services and the temporal shifts in the organisational and policy context that shape practice. However in most accounts these dimensions tend to be analytically separated. It will be argued here that this risks reinforcing prevailing static notions of knowledge in the mental health field. It will be proposed instead that it is necessary to integrate these to develop a more dynamic understanding of the relationship between knowledge, action and context. This requires more detailed theoretical elaboration which is provided in the next section.

This second part of the thesis provides an overview of the theoretical positioning of the study, and provides justification for the methodology and methods employed. Chapter 4 presents a critique of the Models Project (Colombo et al., 2003), an influential study which, it is argued, represents an exemplar of static, reified conceptualisations of knowledge in the mental health service domain. It is suggested that a more dynamic alternative incorporating forms of contextually situated as well as theoretical knowledge is required in a complex open system such as the mental health team. Rhodes' (1993) pentimento framework will be proposed as a suitable means to achieve this. However an epistemological reconstruction of this model drawing on Bhaskar and Danermark's (2006) critical realist notion of the laminated system was required. The resulting reformulation of the pentimento incorporates both diachronic (spatio-temporal) and synchronic (micro-macro scale) dimensions to

provide a more compelling framework for conceptualising the relationship between forms of knowledge and the context of mental health practice.

In Chapter 5 the study's primary methods of participant observation and in-depth interviews will be described. The chapter will then outline in detail the procedures followed in data analysis and explicate the use of Layder's (1998) notion of adaptive theory and 'orienting concepts'. This involved a dynamic retroductive interchange between existing and emergent theory to produce the novel framework noted in the previous chapter, the extended and reformulated pentimento.

The third section of the thesis presents the findings from the study and draws conclusions from them. The findings take the form of two chapters providing detailed case studies and a third chapter that explores CMHT workers' experiences of contemporary reconfigurations of policy and practice. In Chapter 6, the intervention of CMHT workers and mental health ward in-patient staff with a service user called Emmanuel (Manu) is discussed. The first part of the chapter takes the form of a sequential narrative of the challenges experienced in Manu's transfer from an in-patient ward to a hostel located in the community over a period of several weeks as articulated by attendees at several multidisciplinary meetings. This draws on field note data and transcriptions of audio-recordings of the meetings. The latter part of the chapter is based on interview data collected several months later where two of the practitioners involved, a mental health nurse and a psychiatrist, reflect on this process. I organise this section according to key dimensions for conceptualising Manu's mental health issues: defining the nature of his mental distress, the forms of

professional judgement and recommended strategies for intervention. These conceptions are linked to the historical and institutional context of practice.

In Chapter 7 the second case study, that of a service user named Alistair, is presented. In a similar format to the preceding chapter, a historical narrative detailing Alistair's experiences both as in-patient, out-patient and then as a service user supported by the CMHT in the community is developed via analysis of field note and case record data. The discussion then proceeds by drawing on interview data to explore the conceptual frameworks underpinning the understandings of this service user's mental health issues utilised by two practitioners working with him, a social worker and a psychiatrist, as well as those of Alistair and his carer. The forms of professional judgement and interventions consequently recommended by these mental health workers are then elaborated along with responses to them from the service user and carer. As in Chapter 6, consideration is given to the ways in which the institutional setting is reshaped over time and its effects on professional practice and service users' experiences.

In Chapter 8 practitioners describe their experiences of the contemporary context of practice. These are then related, in particular, to the neoliberal reconfiguration of the CMHT setting. The chapter goes on to detail the perceived effects of these processes on practitioners' interactions with service users, forms of intervention and ways of conceptualising mental distress. It will also explore forms of resistance to these developments. The chapter will thus provide greater context for the themes detailed in the case studies.

Chapter 9 draws the analytical strands from the preceding three chapters together. These are then linked to the historical strata in the pentimento, and are placed in the context of levels of scale from micro to macro. This is used to justify the historical and epistemological reconstruction and extension of the laminated system of the pentimento that is necessary for a satisfactorily dynamic understanding of knowledge in the mental health field.

The thesis concludes with Chapter 10. In this section the implications of the study for mental health policy and practice are considered, as well as the prospects for social perspectives and democratisation of the field. This chapter will also critically reflect on the methodology, the model developed and consider directions for future research emerging from this project.

2. PERSPECTIVES ON MENTAL DISTRESS

2.0 Introduction

Having provided an overview of structure in the previous chapter, the thesis will now proceed to explore the contested nature of mental distress by providing a concise summary of some of the key perspectives within the mental health field.

2.1 Overview of perspectives on mental distress

Mental distress is conceptualised in a number of different ways. This has found expression in the diverse range of explanatory frameworks utilised by practitioners, service users, carers and others to understand and define such experiences. Professional training and disciplinary background tends to orient the practice of mental health professionals and this is apparent in relation to understandings of mental distress (Coppock and Hopton, 2000). The various models of mental distress utilised by the occupational groups in this field have been conceptualised as articulations of their professional ideologies and knowledge bases (Abbott and Wallace, 1990). These encompass a broad range of positions from biomedical models of illness and psychopathology, through psychological and psychosocial orientations, to social perspectives informed by sociological theory and recovery models underpinned by conceptions of user empowerment (Anthony, 1993; Read et al., 2004; Davies and Bhugra, 2004). Whilst the predominant framework informing

mental health provision remains the biomedical model (Tew, 2005, 2011; Pilgrim, 2002) this has been subject to recent challenge. The biopsychosocial model, proponents argue, has the capacity to inform a more integrative form of mental health practice by incorporating significant aspects of the above frameworks (Pritchard, 2006).

The chapter will now provide an overview of these key theoretical perspectives for understanding mental distress. Each approach will be presented in concise form to articulate its main features.

2.2 Biomedical model

The biomedical model was the pre-eminent framework during the twentieth century (Coppock and Hopton, 2000) and continues to remain central to the identity of psychiatry (Pfeffer and Stein, 1998). This reflects its status and history as a clinical discipline and branch of medicine. The characteristics of this model include “specific aetiology, a predictable course, manifestations described in terms of symptoms and signs, and a predictable outcome modified by specific treatments” (Pfeffer and Stein 1998, p.1251). According to this perspective psychopathology is determined by physiological processes (Davies and Bhugra, 2004). In particular, biomedical theories implicate the functioning of synaptic neurotransmitters (such dopamine and serotonin) or intracellular processes in the aetiology of mental ‘illness’ (Ross and Pam 1995) (cited in Kinderman 2005). While there may be recognition of the role of

multiple causative factors, biomedical model theorists nonetheless maintain that the locus of the disease process is 'inside' the person (Clare, 1997).

It is claimed that strong evidence in support of the biomedical model is provided by genetic studies (Kety et al., 1994, Hamilton, 2008). However this has been contested (Joseph, 2006; Peroutka, 1997; Kendler, 2005; Sanders et al., 2008). There have also been debates concerning the validity and reliability of diagnostic practices (Clare, 1997) and widespread criticism of the fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013) widely referred to as DSM-5 (Watts, 2012; Gornall, 2013; British Psychological Society, 2013; Hearing Voices Network England, 2013). These debates are illustrative of increasingly prominent concerns about the implications of over-medicalising mental health care (Sharfstein, 2005; Eisenberg, 1995; Pérez-Álvarez et al., 2008; Healy, 1997; Healy, 2006a; Moncrieff, 2009a; Kirsch, 2009; Lawton-Smith et al., 2008). Notwithstanding these prominent critiques, a consensus in psychiatry not only remains but has strengthened in support of the biomedical approach (Ghaemi, 2006).

2.3 Psychological models

In competition with the biomedical approach are two major psychological models of causation: the behavioural/cognitive-behavioural model and the psychodynamic model. These will be set out below.

2.3.1 Behavioural and cognitive-behavioural models

The behavioural model proposes that the symptoms of neurosis have been produced through maladaptive learning processes and sustained by either the resultant positive or the absence of negative effects. This approach advocates a process of re-learning through behavioural therapy (Davies and Bhugra, 2004).

The cognitive model emerged as a pragmatic adaption of the behavioural model after the decline of strict behaviourism. This approach is concerned with how elements of human reasoning and thinking processes impact on psychopathology. The cognitive-behavioural model was a later development integrating elements of both the cognitive and behavioural models and is underpinned by the assumption that beliefs, cognitions and faulty patterns of learning contribute to disorders of mood. Such problems it is claimed require the intervention of cognitive-behavioural therapy (CBT) to change thought and behaviour and thus improve mood (Davies and Bhugra, 2004). CBT has been extensively promoted in recent mental health policy (Layard, 2005; Clark, 2011).

2.3.2 Psychodynamic model

The other major psychological model is the psychodynamic. This focuses on the impact of early childhood experiences, and the conflicts that these produce of which people may remain unaware, as they are predominantly unconscious. However, if such conflicts result in the breakdown of the ego then symptoms may result.

Psychodynamic therapy aims to explore the meanings of current feelings and behaviours through past events in order to make latent conflict conscious and allow conflicts to be more effectively managed. This is mediated through a process of transference in the therapeutic relationship (Davies and Bhugra, 2004).

2.4 Biopsychosocial model

The biopsychosocial (BPS) model is also prominent in the field and seeks to offer a framework that integrates biomedical and psychological as well as social dimensions. The BPS approach developed by Engel (1977) (cited in Pilgrim, 2002) is underpinned by the argument that mental distress arises in a systemic context and as such warrants a conception of an ontology constituted by multiple levels from the biological to the social (Pilgrim, 2002). It is claimed that the BPS model is currently the primary paradigm within psychiatry, and has been promoted to inform practice across the mental health professions (Ghaemi, 2006; Pritchard, 2006). However it has proven controversial amongst proponents of both biomedical and social approaches (Sharfstein, 2005; Colombo, 2008; Read et al., 2004; Pilgrim, 2002; Pilgrim et al., 2008), the model may be more indicative of the pragmatic co-existence of a range of professional groups within a negotiated order in integrated teams rather than a genuine integrative orthodoxy (Pilgrim, 2002).

2.5 Lay perspectives and folk models

There is a growing literature problematising the privileging of the explanatory frameworks of Western psychiatry (and psychology) over other professional, folk and spiritual systems for understanding mental distress (Gaines, 1992; Kleinman, 1988; Bhui and Bhugra, 2002; Colombo, 2008). However globalisation is generating homogenising tendencies that undermine diverse cultural understandings of mental distress (Watters, 2010; Fernando, 2011).

2.6 Recovery model

The recovery model is another expression of the critique of mainstream psychiatry developing over the last two decades, and has an increasingly high profile within contemporary UK mental health policy (DH, 2001; NIMHE, 2005; HM Government, 2009). It emerged from critiques of inevitable chronicity and a growing service user/consumer literature documenting lived experiences of recovery (Warner, 2004; Anthony, 2000). However, it is a contested concept, with no universal definition (Bonney and Stickley, 2008; Lester and Gask, 2006; Repper and Perkins, 2003). There is a tension between clinical definitions of recovery and subjective orientations to self-management and growth (Roberts and Wolfson, 2004). Contemporary understandings involve a shift from the former to the latter, whereby an exclusively clinical perspective is superseded by a more personal approach that is consonant with the meanings and values of the individual (Anthony, 1993; SCIE, 2007). However though the recovery model's wide conceptual parameters have been

subject to critique (Ramon et al., 2007; Wallcraft, 2005), there have been some attempts at detailed elaboration (Jacobson and Greenley, 2001; Lester and Gask, 2006; Hopper, 2007; Wallcraft, 2010).

2.7 Social and sociological perspectives

The chapter will now turn from recovery to social approaches. It will be argued that it is more appropriate to speak of a range of related social perspectives rather than posit a single coherent social model (Tew, 2005). Pilgrim and Rogers (1999a) have usefully proposed four key social (or sociological) perspectives for understanding mental distress. These are: social causation, social reaction (labelling theory), social constructivism and social (or critical) realism. These will be outlined before adding a fifth: 'modern' social models.

2.7.1 Social causation

The social causation framework proposes that mental distress is linked to social disadvantage and stress produced by inequalities and social divisions such as social class, race or gender. It is argued that mental distress should be understood less in terms of individual pathology and rather as a response to relative deprivation and social injustice (Friedli, 2009).

This tradition has produced seminal studies which have identified the ways in which social factors can precipitate depression (e.g. Brown and Harris, 1978) or

schizophrenic episodes (Brown and Birley, 1968) (cited in Murray, 1997). Indeed, the 'social causation hypothesis' has experienced a revival of interest in the last decade, with factors such as racism, gender discrimination, inequality, poverty and migration identified as increasing risk (e.g. Murali and Oyeboode, 2004; Tribe, 2002; Chakraborty and McKenzie, 2002; Astbury and Cabral de Mello, 2000; Friedli, 2009; Wilkinson and Pickett, 2010). However there is a risk with this approach that psychiatric diagnoses are given the status of social facts (Boyle, 2002).

2.7.2 Societal reaction (labelling theory)

Labelling theory gained particular prominence during the 1960s. Adherents are concerned with how certain forms of deviance such as madness are responded to and categorised, and also how social roles such as that of the psychiatric patient are negotiated and maintained. Key theorists include Scheff and Goffman.

Scheff (1984) proposes a sociological theory comprised of two fundamental components: social role and societal reaction. Employing the notion of deviance, Scheff (1984) identifies the way in which the 'mentally ill' violate societal norms that constitute a wider system of social control. Such deviance elicits a response characterised by stigma, segregation and labelling. Goffman (1961) is less concerned with the nature of mental illness than with the identity of the self that emerges out of everyday social interaction in total institutions such as asylums. Goffman describes a 'moral career' from person to patient that is completed on the psychiatric ward.

To some limited extent, the notions of *labelling* and *institutionalisation* have been recognised and incorporated into the psychiatric worldview (Pilgrim and Rogers, 1999a).

2.7.3 Social constructivism

Though social constructivism includes a diverse and sometimes contradictory range of theoretical positions, a number of common characteristics can be identified. These include a problematisation of reality which is viewed, to varying degrees, as a product of human activity, and the implication of power relations in definitions of reality.

In the field of mental health this approach was developed most influentially by Szasz and Foucault (Pilgrim and Rogers, 1999a). Szasz (1968, 1998) problematises the status of mental illness, regarding it as a 'convenient myth' while Foucault, and subsequent theorists influenced by his work, describe the exercise of power through forms of knowledge (Foucault, 2001; Brooker, 2003; Miller and Rose, 1986; Thomas and Bracken, 2004). The influence of this approach is apparent in the growing recognition of alternatives to dominant biomedical perspectives, such as service user knowledge (Beresford, 2004, 2005).

2.7.4 Social (or critical) realism

The fourth social perspective is that of *social realism* which is informed by a critical realist (CR) approach. Pilgrim and Bentall (1999) argue that two forms of reductionism predominate and polarise in the mental health field. These are empiricism (the biomedical model) and constructivism (i.e. mental illness is an outcome of professionals' discursive practices). CR moves beyond the constraints of these empiricist and constructivist positions. The integrative potentials of CR usefully enable social constructivist understandings, for instance critical analysis of the impacts of professional knowledges and interests, to be combined with recognition of the reality of mental distress and the role of material and social causation (Pilgrim and Bentall, 1999).

CR will be utilised as the theoretical and epistemological underpinning for this thesis and will, therefore, be elaborated in greater detail in Chapters 4 and 5.

2.8 'Modern' social models

This overview of social perspectives will conclude with consideration of 'modern' social models (Duggan et al., 2002). The latter rubric has been adopted to describe a resurgence of interest in social models of mental distress over the last decade stimulated by user and carer movements and networks, as well as practitioners and academics from across the mental health disciplines (Beresford, 2002, 2004; Tew, 2005; Gould, 2009). While an explicit model comparable to the social model of

disability has not emerged, and there are some ethico-political tensions within the debates (freedom/libertarianism versus rights to care and support), these movements have challenged the continued hegemony of the biomedical model (Beresford, 2004; Spandler, 2006; Spandler and Stickley, 2011). These new orientations have found institutional expression through the formation of alliances such as the Social Perspectives and Hearing Voices Networks.

2.9 Summary

This chapter has presented, in concise form, some key perspectives for understanding mental distress. However it will be argued in the thesis that forms of knowledge emerge in dynamic inter-relationship with their social and material context. In recognition of this, the next chapter will provide a detailed overview of the organisation of the setting within which mental health practice takes place.

3. THE INSTITUTIONAL AND POLICY CONTEXT OF PRACTICE

3.0 Introduction

This aim of this chapter is to provide an overview of the institutional and policy context of mental health practice. The chapter will begin by considering sociological perspectives on professionalism. However it will be argued that such accounts do not satisfactorily account for the way in which the activity of the occupational groups in this field are being reconfigured by neoliberal managerialist reforms. It will be proposed that the labour process approach provides a more persuasive account as marketisation and escalating administrative demands reshape the nature of professional work within this domain. Three additional features of the contemporary mental health policy and practice landscape are also considered. The first is the integration of a range of professional groups within an integrated team framework. The second is the increasing influence of service users and carers on the structures of service provision, though there are ambiguities and contradictions in this process that will be explored under the rubric of responsabilisation. The third feature is the increasing emphasis on risk management in policy, and its coercive implications for practice. The chapter will conclude with consideration of the inter-relationship of these processes in the context of neoliberal welfare policy reform.

3.1 The professions and the labour process

There are a number of alternative frameworks for conceptualising professional practice. These include categorising occupational groups according to proposed archetypal characteristics or understanding professionalism through the prism of inter-professional power relations and competition. However these sociological approaches have tended to underplay the tension between ideological conceptions of the professions and the labour process itself. This section of the chapter will therefore begin by providing an overview and critique of key perspectives within the sociology of the professions and then go on to offer an alternative labour process formulation of professional practice in mental health services. It will be argued that the contemporary reconfiguration of these practices should be understood in the context of the marketisation of the health and social care sector under the rubric of public service 'modernisation'. Therefore an examination of the changing nature of the labour process in mental health services will be located within an analysis of managerialist reforms and the broader context of neoliberalism.

3.1.1 The Sociology of the professions

Trait theory was the dominant orientation within early explorations of the nature of professionalism. This approach defined professions in terms of the characteristic features they possess such as a specialist knowledge base requiring a lengthy training period and codes of ethics (MacDonald, 1995). According to this approach medicine is considered a profession, while occupational groups such as nursing and

social work meet only some of these criteria and are thus considered semi-professions (Etzioni, 1969).

However, such approaches were problematised by subsequent *market strategy* theorists who emphasised issues of power and conflict. An example is the neo-Weberian framework developed by Freidson (1994). He argued that trait theorists tended to emphasise the professions' socially cohesive aspects, whereas professional claims were in fact ideological in nature. His concepts of professional dominance, social closure and organised autonomy have been influential and will now be described and related to developments in the contemporary health field.

The first, *social closure*, involves the assertion of monopoly control over particular areas of practice by occupational groups seeking to secure socio-economic advantage. This market strategy approach has been successfully deployed by medicine in the UK since the Medical Registration Act 1858 enshrined sole rights to practice in this field, to the exclusion of other models such as those found in alternative medicine (Dobraszczyk 1989). However in the mental health field psychology has recently challenged psychiatry's monopoly with regard to the behavioural treatment of people with neurotic conditions (Rogers and Pilgrim, 1996). The second and related concept is *organised autonomy*, or legal monopoly over particular aspects of work possessed by an occupational group. In the case of psychiatry, maintaining an exclusive right to prescribe medication was an element in the maintenance of dominance in the mental health field. However this too has now come under challenge as the nursing profession has been granted legal sanction to

adopt a prescribing role (Cooper et al., 2012). The third strategy, referred to as *professional dominance*, concerns the wielding of authority by one occupational group over others (Freidson, 1970) (cited in Pilgrim and Rogers 1999a). Such strategies have often been associated with psychiatry's leadership role within mental health services, and also has a gendered dimension with medical practitioners predominantly male, and nursing or social work professionals predominantly female (Davies, 1996).

However, Freidson's account of professionalism has been criticised as failing to adequately reflect contemporary trends (Evetts, 2010). For neo-Weberians such as Freidson, the defining characteristic of professionalism has been occupational control of the work, yet this has been marginalised in a context where, increasingly, such control is defined by organisations or the state and the logics of managerialism and the market predominate (Evetts, 2010; Evetts, 2011). These significant changes in the organisation and management of UK public services since the 1980s have been described as the 'new public management' (NPM) (Hannigan, 1998; Walshe, 2002). Governmental action based on de-regulation and market-based reform of public services has represented a challenge to professional power (Hannigan, 1998) and undermined modes of professional dominance, including that of medicine (Harrison and Ahmed, 2000; Evetts, 1999).

3.1.2 The labour process approach

While the neo-Weberian approach usefully highlights relations of professional power and dominance, it tends to underplay the crucial role of reforms to the labour process within professional practice. The foregrounding of the latter has been emblematic of the other main approach within the sociology of the professions: the structural approach of Marxism. Here, in contrast to the market strategists' focus on horizontal relationships, the dynamics of professionals' vertical structural locations are investigated (Pilgrim and Rogers, 1999a).

An important early example of this position was that of Gough (1979), who noted the routinisation and bureaucratisation of work for doctors, nurses and social workers, which produced a clash with the ethic of professionalism often resulting in identification amongst many with trade union strategies of resistance traditionally more common amongst manual workers. However Gough's account was more concerned with the broader political-economic context than the workplace routines and practices of these occupational groups. A much more detailed and systematic formulation of the labour process was developed by Braverman (1974) in a groundbreaking text where he argued that 'proletarianisation' was fragmenting and devaluing professional work through escalating administrative control. Harris (1998; 2003) applied this approach to social work, but also drew on the work of Derber (1983) to extend Braverman's analysis.

Harris (1998; 2003) argued that, in the post-Seebohm Report 'bureau-professional' era of the 1970s and 1980s, there was an absence of significant external control on social workers' means of practice, and thus they had considerable *technical* autonomy and discretion. This was apparent in the broad absence of specific assessment criteria and workload targets, the granting of considerable discretion with regard to methods of intervention, and a permissive approach to managerial supervision. There nonetheless remained a degree of *ideological* subordination during this period, with the requirements of the social democratic welfare state setting legal and institutional constraints on the scope of practice (Harris, 2003).

However the 1990s marked a shift from this bureau-professional mode to managerialism, with a new culture of capitalism colonising the public sector. The NHS and Community Care Act (NHSCCA) 1990 led to the marketisation and residualisation of social services. The locus of *technical* control shifted accordingly during this period. A transformation in terms of reduced discretion at the frontline was apparent with the implementation of standardised procedures and performance audit regimes that are monitored by information technology systems. The context is a 'top-down' approach where priorities and objectives were more clearly defined at senior management level and set out in performance targets, with a much greater consciousness of financial and budget considerations (Harris, 1998). Moreover, at the *ideological* level, this external market orientation led to significant changes in internal managerial cultures, with the adoption of 'quasi-business' and consumerist discourses modelled on the private sector. Social workers were redefined as 'care managers' and given a more explicit rationing role (Harris, 2003).

Similarities and differences are apparent in the impact of these reforms on the labour process of NHS workers in mental health services. The path of neoliberal managerialist reconfiguration began with the introduction in 1991 of a US-influenced 'case management' approach known as the Care Programme Approach (CPA) which was broadly contemporaneous with the care management reforms of the NHSCCA 1990 (Lester and Glasby, 2010). However, while care management formed part of CMHT workers' role, the space for practitioners to assert *technical* discretion in CMHT work has tended to be significantly greater than in social services environments since the 1990s. Evans (2010) has identified a continuing role for the bureau-professionalism described above within CMHT settings, and suggests this may be linked to the less intensive penetration of managerialism and a greater emphasis on risk management.

However a number of recent reforms are changing this context of practice. Perhaps the most significant has been the introduction of NHS Foundation Trusts (FT) as service providers from 2003. These are corporate entities with independence from government control and are expected to produce surpluses through competitive activity in health care markets. Professional practice has been shaped by the market orientation of these new institutions (Pollock et al., 2003). Moreover the simultaneous implementation of Payment by Results (PbR) and establishment of FTs marked a step change on the path towards neoliberal restructuring of the NHS (Lister, 2008). While PbR's introduction to mental health services has been much later than other parts of the NHS (it was implemented in full from April 2013) and therefore its effects

on practice are only beginning to emerge, mental health practitioners have been subjected to other significant managerialist reforms. These include an escalating requirement to collect data and meet key performance indicators for a wide range of purposes such as local authority contractual targets, Monitor (independent NHS regulator) Compliance Framework information, and Commissioning for Quality and Innovation (CQUIN) payment framework goals. These are additional to NHS Trusts' own internal targets⁷. This thesis will examine the way that these reconfigurations have placed constraints on the discretionary spaces available to CMHT practitioners.

3.1.3 Neoliberal managerialism, marketisation and the labour process

An implicit dimension of the above discussion is that changes to the welfare labour process should be understood in the context of broader developments in the arena of political economy. Recent reforms of public sector work have been informed by a neoliberal policy framework. This section will therefore offer a brief definition and description of neoliberalism and outline the mechanisms through which it is reshaping the contemporary form of the welfare state. The thesis will then return to

⁷ Performance indicators in contemporary mental health services tend to align with managerial conceptions of efficiency and throughput, and orient summatively to supply and service content (Clarkson and Challis, 2002). This contrasts with the earlier Keynesian welfare regime where professionals tended to have greater discretion, within the boundaries of their particular professional knowledge base, to define the goals (rather than measures) of their work (Harris and Unwin, 2009). These could be considered to represent, respectively, *business* and *professional* orientations for performance management (Pollitt, 1997). Dimensions, particularly those prioritised by service users, such as access, collective provision and user-defined outcomes have tended to be marginalised (Clarkson and Challis, 2002; Beresford and Branfield, 2006). This might be addressed with tools that are more formative and process-oriented such as user-focused monitoring (Rose et al., 1998).

the contemporary welfare labour process under neoliberal managerialism, describing its features and then suggesting possible spaces of resistance.

In the post war period from 1945 to the 1970s the dominant political-economic theory was Keynesian interventionism, characterised by a mixed economy, nationalisation and state provision of welfare (Ferguson et al., 2002). This provided a context for the bureau-professionalism described by Harris (1998; 2003). However by the 1980s this approach was challenged from the political right by advocates of neoliberalism. This theory argues for economic restructuring in order to 'liberate' markets, and ensure that free trade and rights to private property are strengthened and extended.

Consequently the role of the state was seen to be a minimal one (Harvey, 2005).

Neoliberalism thus represents a resurrection of neoclassical 'laissez faire' economics at the ideological level (Harman, 2008). This policy agenda underpinned the programmes of the 1979-1990 Conservative and subsequent New Labour administrations (Callinicos, 2001). The neoliberal programme has been one of deregulation and privatisation, while in the sphere of social and welfare provision this has tended to take the form of marketisation and contracting out. Although these reforms have not had the effect of reducing public spending overall, the widespread perception of welfare retrenchment has operated to depoliticise social provision, thus delegitimising the claims to access welfare of certain groups, whilst also enabling the implementation of increased workload burdens on welfare workers (Harman, 2008).

New public management (NPM) represents an important strategy for the integration of the values and practices of the market into the public sector (Clarke and Newman,

1997). NPM holds that the public sector is inefficient due to an absence of market incentives (property rights theory) and the undue influence of particular interest groups within government (public choice theory). NPM proponents argue for the reshaping of public services through contracting out and increasing private sector involvement to shift the locus of control from state actors to consumers in order to improve cost efficiency (Pollock and Price, 2011). As a result, public service bureaucracies are dismantled, but NPM also operates at the ideological level to introduce a performance management culture and inculcate business values (Newman, 2007). Clarke (2004) notes that this neoliberal policy orientation delineates multiple 'routes to market'. Whilst within statutory mental health services direct privatisation⁸ has not been a primary strategy, marketisation has proceeded via other mechanisms such the creation of quasi-market bodies e.g. Foundation Trusts. Price et al. (2011) argue that while such public corporations may remain nominally within the public sector, this disguises a reduction in public control and consequent loss of ability to secure equity goals. Pollock and Price (2011) identify such measures as part of a 20-year process within the NHS representing an incremental transition from internal towards external markets.

Leys (2001; Player and Leys, 2008) have developed an analytical framework for understanding such processes of public sector market transition. He argues that in order to convert public sector agencies such as the NHS and social services into a private market a four-stage process is required, three of which are particularly

⁸ Although the conditions for full privatisation of the statutory mental health field may be somewhat restricted by the low income levels of a large proportion of service users (Pilgrim, 2012), there remain multiple alternative marketisation strategies to facilitate increasing capital accumulation in this field (Clarke, 2004).

relevant to the context of Southville CMHT. First, services must be commodified - broken down and reconfigured as discrete units of output that can be produced or packaged in a more or less standardized way which renders them amenable to productivity-increasing measures; second, patients and service users must be persuaded to want these as commodities – for instance through the concept of ‘choice’; and third, the labour force must be redefined as producers of commodities within new organisational formats and structures (e.g. purchaser/provider split, outsourcing). A key implication of the second and third stages of this process is the reconstitution of practitioners and service users as entrepreneurs and consumers in a social care marketplace. Meanwhile the reconfiguration of welfare work into discrete units for the market seems an apt description of the costing and standardisation of service pathways within the recently introduced PbR mental health clustering system noted above. PbR involves the allocation of mental health service users to a diagnosis-related category or ‘cluster’ to determine the type of care they receive in line with new individualised funding arrangements. The clustering process facilitates the reconfiguring of services as commodified units more amenable to a competitive orientation within statutory mental health services (MacDonald and Elphick, 2011) and thus represents a significant extension and deepening of neoliberal marketisation within the NHS setting.

Another key dimension of neoliberal welfare is the reconfiguration of welfare work already noted above. The particular character of the transformation of the public sector labour process is usefully conveyed by Law and Mooney (2007) in their notion of ‘strenuous welfarism’. They describe a tendency towards calculable quantification

to enable comparative indicators of performance in a quasi-market setting that results in the attempt by institutions,

[T]o transform the tacit knowledge embedded in particular disciplines and organisational settings into the kind of codified knowledge that could be made subject to generic managerial measurements and controls. (Law and Mooney, 2007, p.43)

This leads to the flexible intensification of worker effort, the loss of breathing space and porous time, and the imposition of administrative burdens that reduce time for care and support of service users. Moreover, when workers submit to target-oriented work to protect themselves from the potential for disciplinary managerial activity then the affective embodied dimensions of worker-service user interaction are negatively impacted, yet the measuring of outputs via audits and targets does not capture this disengagement process.

However, this proceeds in complex, uneven and incomplete ways and, in the context of a highly stratified labour force, affects different groups of workers in different ways. Like Harris (2003), Law and Mooney (2007; 2008) note that there is an inherent tension between processes of bureaucratisation and deskilling of welfare professionals and the performative discretion and task autonomy of models of professionalism. As a result,

[E]ven under strenuous welfare regimes, work typically retains something of the character of an artisanal labour process where some discretion is retained over how to carry out predetermined tasks. (Law and Mooney, 2007, p.45).

Harris and White (2009) argue that these 'discretionary spaces' provide opportunities to challenge the constraints imposed by neoliberal managerialism. Such spaces for mental health practitioners to work in participative, user-oriented and democratic

ways have been described by Stark et al. (2000; 2002) as *ecologies of practice*, juggled precariously with the resource-oriented, accountability-driven *economies of performance* of managerialism.

It is also important to note that the points where these managerial and professional processes are in tension produce resistance that may be channelled through trade union structures or emerge in other more spontaneous forms (Fairbrother and Poynter, 2001). These might involve small-scale 'quiet challenges' to managerialism in everyday practice such as the exercise of professional discretion in relation to assessments or the strategic circumvention of particular organisational obstacles in order to secure greater resources for service users (Harris and White, 2009). However, as identified earlier, the notion of professionalism itself may represent a countervailing tendency in opposition to managerialism (Evetts, 2003). An example from social work, is the increasingly active collective resistance to reforms seeking to deskill this professional group that has found expression in a defence of an ethic of professionalism linked to values of social justice (Lavalette, 2007).

In summary, this section has engaged in a critical review of some key sociological notions of the professions and neo-Weberian critiques emphasising power relationships. It has then proposed the labour process approach as a more satisfactory alternative for developing an understanding of the dynamics of professional practice within the mental health field in the context of neoliberal managerialism. However, the fundamental reshaping of mental health work by neoliberal managerialism has a number of other salient features that will be

described in the remaining sections of this chapter. The first is the reorganisation of mental health professionals into integrated teams. The second is the increase in the structural influence of service users, a welcome though ambiguous development that holds in tension two contradictory phenomena: the impact of collective service user movements on the one hand and an orientation to individualised consumerism in public services in the neoliberal era on the other. The third is the prominence of concerns around risk.

3.2 Interprofessional working

The predominant organisational context of contemporary mental health services is the integrated health and social care trust. Here, practitioners from different disciplinary backgrounds such as psychiatry, nursing and social work are co-located within an integrated team framework (Lester and Glasby, 2006). The establishment of integrated teams has been a key element of the managerialist reform of mental health services (Rogers and Pilgrim, 2001). Teamworking has become a buzzword and is argued to improve performance, reduce costs and improve user access and satisfaction (for instance, DH, 2000). However, empirical research evidence is more equivocal on the latter's effectiveness (Jelphs and Dickinson, 2008).

One prominent feature of integrated teams has been inter-professional or 'tribal' conflict (Beattie, 1995). The dual identifications, with team as well as profession, have also resulted in tensions between these identities, and the undermining of the significant relationship between personal and professional identity (Onyett, 2003).

Teamworking has also led to problems of reduced role clarity, with genericism leading to role 'blurring' (Onyett et al., 1997; Evetts, 1999; Brown et al., 2000; Rushmer and Pallis, 2003; Payne, 2006). These processes have a detrimental effect on staff morale and intensify levels of stress and burnout (Onyett et al., 1997; Evans et al., 2006; Carpenter et al., 2003). In the context of managerialist reform Hugman (2003) argues that genericism signifies deprofessionalisation rather than greater interprofessional integration and for this reason 'tribal' conflicts should be understood as a defence of professionalism and thus a form of resistance.

There is a further significant contributory factor to the tensions described above, conflict over values. The secondment of social workers to NHS mental health services integrates members of this occupational group within a medically dominated hierarchy (Peck and Norman, 1999; Carpenter et al., 2003). In spite of claims noted in Chapter 2 that an inclusive biopsychosocial model is predominant here, social workers and other mental health practitioners have found their practice medicalised, and social and psychosocial models marginalised (Tew, 2005; Yip, 2004, Evans et al., 2006). The Models Project research study, which will be discussed in greater detail in the next chapter, related communication difficulties and forms of conflict within multidisciplinary teams to the differing implicit models of mental distress (and their underlying value systems) utilised by the various occupational groups in the mental health field (Colombo et al., 2003; Fulford and Colombo, 2004; Colombo, 2008).

The normative dimension is also visible in relation to the other key rationale for interprofessional collaboration, the potential benefits to service users. Professional

perspectives do not necessarily align on this question, moreover Hugman (2003) has identified the consumerist construction of this perspective as representing collusion with the managerialist critique of professionalism. These issues will be considered in the following section, which discusses the relationship between user involvement and movements and the consumerist 'responsibilisation' of service users and carers under neoliberalism. This next section draws on ideas initially developed in Moth (2008b).

3.3 Service user involvement

The growth of the structural influence of patients and service users within contemporary health services is a significant development that must be incorporated into an understanding of professional practice (Bourgeault et al., 2007). These trends are inextricably bound up with the development of disability movement activism (Beresford, 2002). Within the mental health field, the development of the service user movement has led to calls for a shift in the balance of power between users and professionals (Hutchinson, 2000) (cited in Lester and Glasby, 2006). This has resulted in increased expectations of service user consultation and involvement within the policy domain, and contributed to a higher profile for user-led and recovery-oriented perspectives in the design and delivery of mental health services (Lester and Glasby, 2006; DH, 2001; NIMHE, 2005; DH, 2011). However these trends have been riven by contradictions underpinned by the tension between two processes: the consolidation of a service user/survivor movement, and the promotion

of consumerism and responsabilisation in public services. These will now be examined in the following section.

3.3.1 Service user/survivor movements

The service user/survivor movement in the UK, beginning with the Mental Patients Union that formed in 1971, was influenced by the critical perspectives and institutions initially marked out by the earlier anti-psychiatrists. The movement developed international links, for instance with the *Psichiatria Democratica* network in Trieste, Italy, and from these by the 1990s the Hearing Voices Network had emerged. Activists involved in this organisation have generated innovative alternatives to psychiatric theory and models of practice by advocating user empowerment via strategies for 'living with voices' (Crossley, 2006). Moreover, such approaches are beginning to attain a higher profile within the mainstream of mental health practice (Bracken, 2001).

3.3.2 Consumerism in public services

However the other key trend since the 1980s has been the promotion by governments of the notion of individual consumerism in public services. One element of this was the construction by NHS managerial elites of alliances with service user groups to further its interests vis-à-vis challenging the institutional power of medicine. These interlocking dynamics of individual 'consumer rights' promoted by neoliberal administrations alongside the increasing prominence of the demands of radical

collectivist survivor movements have served to shape the contemporary context of mental health practice in contradictory ways (Rogers and Pilgrim, 2001). This is apparent in the contestation over some key concepts in this field, and these tensions will now be explored.

One significant aspect of the developments outlined above is that post-1997 healthcare reforms have tended to be presented as a democratic and citizen-led recasting of the NHS and mental health services (Bracken and Thomas, 2005). Such claims have been associated with the proliferation of particular concepts and agendas in the policy and practice domain. These include increased *participation* and *active self-government*. These have been promoted in the mental health field through notions of empowerment, choice and recovery (Daly, 2003). Though these concepts frequently emerged through contestation by service users and their allies of the prevailing unequal power relations within welfare services (Barnes and Bowl, 2001), the particular meanings associated with them should be understood as context dependent and contested. There is a powerful tension between their origins in citizenship discourses and the activity of social movements and their adaptation into mental health policy and practice in the context of neoliberalism and consumerism.

One example is the concept is *empowerment*, an ambiguous and often imprecisely used term (Tew, 2006). This has been articulated through two competing lenses: 'collectivist social action' and 'individualist consumerism' (Masterson and Owen, 2006). The former developed out of the collectivist mobilisation of social movements of the 1960s, while the aetiology of the latter is to be found in New Right ideology and

its promotion of individual service users as customers. Another seemingly ubiquitous concept in welfare services is *participation*, promoted in numerous policy initiatives (DH, 2004). However its contested nature is apparent in the proliferation of official discourses through which it is mobilised. Barnes et al. (2007) identify at least four policy discourses of participating publics: responsible, empowered, consuming and stakeholding. As with the notion of empowerment, the tensions and ambiguities at the conceptual and practical levels emerge in the context of political and social contestation over meaning (Barnes et al., 2007), and two prominent and competing conceptualisations linked to social movement and neoliberal ideology are visible. The neoliberal orientation, articulated as participative governance, claims that the number of 'invited spaces' that facilitate the engagement of service users/consumers with institutions has widened. However this underestimates the potential for participation to become a "technology of legitimation" of organisational authority in view of the structural resistance to power sharing within institutions (Carr, 2007, p.271). In contrast, an activist conception of participation foregrounds the potential for resistance to the constraining dynamic of official policy processes. By articulating demands that transcend such limitations service users and others may contribute to the development of new 'democratic spaces' (Cornwall, 2004).

A third concept is that of 'choice' which has been extensively promoted in the policy domain over the last decade (DH, 2003) and forms an integral part of the recovery model (SCMH, 2006). Hopton (2006) notes 'substantial continuity' between the way in which choice is constructed in these policy frameworks and the discourse of consumerism. In mental health services, the mobilisation of choice rests upon "the

twin pillars of competition and plurality of provision” (Valsraj and Gardner, 2007, p.61).

An important component of this agenda has been the development of individual budget and direct payment mechanisms, which facilitate the planning and purchase of support packages by service users (Ridley and Jones, 2003).

Direct payments (DPs) highlight some of the complexities involved in the debates around conceptions of choice and independence in the mental health field. This approach is rooted in the philosophy of independent living and the social model of disability, and has developed in the context of disabled people’s activism, critiques of the medical model and demands from user movements for greater control and self-determination⁹. Moreover, as Spandler (2004) notes, there is growing evidence for their effectiveness, and support for DPs reflects users’ experiences of the oppressive and bureaucratic dimensions of, and insensitivity to individual needs within, the Keynesian welfare state.

However these grievances have been skilfully appropriated by neoliberal policymakers to articulate a “rhetoric of producer versus consumer choice” (Harris, 1999, p.921). DPs and associated reforms represent, as Ferguson (2007) notes, a transfer of risk from the state to the individual, and this individualising orientation raises concerns that the potential for collective self-help movements will be undermined (Spandler, 2004). Another significant tension that arises in this context is between choice and equity (Clarke et al., 2007). This is generated by the interaction

⁹ This indicates the potential for alignments between mental health service user and disabled people’s movements produced by shared interests and struggles in relation to the welfare state (Beresford, 2002) (cited in Pilgrim and Tomasini, 2012).

between welfare retrenchment and an unequal distribution of the resources that facilitate and enable choice such as social capital. Clarke et al. (2007, p.107) argue that the “knowledge, articulacy, advocacy and assertiveness” of middle class service users advantageously positions them to access a disproportionate share of public goods in comparison to those from lower income and working class backgrounds.

This section has explored some of the key conceptual tensions in contemporary welfare discourses. The last two decades has seen both the growth of a significant and active UK mental health service user/survivor movement (Ferguson, 2000) and also the emergence of neoliberalism as the most influential contemporary articulation in the policy field (Barnes and Bowl, 2001). As a consequence, welfare policies emerging in this socially and politically contested context tend to reflect uneasy accommodations and convergences of social justice and consumerist concerns.

These tensions are also apparent in debates and struggles, explored in the next section, around the notion ‘responsibilisation’.

3.3.3 Responsibilisation in mental health services

The preceding section has detailed conflicts in recent welfare policy around concepts such as empowerment, participation and choice. An important dimension of this is the recent orientation in policy to greater consumer self-care and self-management, a perspective with considerable support amongst many service users. However, in the context of neoliberal welfare reform, this has also attracted critical consideration

utilising the notion of responsibilisation (Carpenter, 2009; Brown and Baker, 2012). The definition and dynamics of this concept and its implications for service users, carers and practitioners will now be explored.

Historically mental health service users have been subject to a range of oppressive forms of intervention and practice. In this context committed groups of service user/survivors frequently express a preference for self-care over 'dependency' on services. This is particularly apparent in the prominence of service users' 'survivor' and 'healing' narratives (Brown and Baker, 2012). These have sometimes moved beyond appeals to individual lifestyle change towards a wholesale refashioning of the individual as an 'empowered expert' in practices of self-care.

However, while the involvement of laypeople in health care is nothing new, a significant shift under neoliberalism has been to harness such participation to promote the notion of 'empowered' consumers utilising welfare resources responsibly. This idea is apparent in, for example, expert patient programmes (Rogers et al., 2009). Here, the idealised individual develops the qualities of 'responsible' and 'active' consumer, and this is manifested in their capacity to work in partnership with services and use them appropriately (i.e. utilising fewer resources) to effectively self-manage their condition (Gilliatt et al., 2000)

In this respect, responsibilisation represents a complex process of individualisation and subjectification of the public domain. Participation tends to be individualised rather than, as previously understood, emergent from communities and collectives. A

fervent emphasis on such individual self-reliance has an implicit potential for 'victim blaming' of those who do not successfully mobilise their personal resources to 'get better' (Brown and Baker, 2012). Moreover the consequent reduction of demands on health and welfare services diverts attention away from the structural determinants of health and the rights of citizens to medical services (Rogers et al., 2009).

Here, some of the tensions in relation to neoliberal welfare described in the previous section are apparent. On the one hand, service users have welcomed the possibilities heralded by mechanisms for self-directed support (Spandler, 2004). However critics argue that these processes do not realise a genuine shift in power, but instead the devolution of responsibility to users in the context of increasingly restricted access to services (Goode et al., 2004) (cited in Brown and Baker, 2012, p.82). For Gilliatt et al. (2000) the outcome is to empower the producer (i.e. the capitalist state) rather than the consumer.

These apparently contradictory dimensions are also visible in relation to practitioners. On the one hand face-to-face work in mental health is increasingly delegated to a combination of less qualified support staff, the service user and their carers as the administrative burden for professionally qualified practitioners rises exponentially (Rogers et al., 2009). Meanwhile, changes in the policy backdrop to community work (as exemplified by the 2007 Mental Health Act amendments described further below) have led to more intensive and draconian risk surveillance and management practices alongside a 'softer' partnership working orientation towards service users (Carpenter, 2009).

This section has illustrated the contested and contradictory nature of service user involvement, which is linked to the tension in mental health policy between two factors: the growth of social movements and consumerist ideology (Beresford, 2005). In the current neoliberal policy context service users have both welcomed structures that enhance self-determination, but such policies may also devolve risks and responsibilities to the individual. Moreover, the goals of enhanced service user choice and empowerment may be undermined by poverty, social exclusion and discrimination (Rankin, 2005). Similarly, an increased emphasis on risk, and coercion towards mental health service users further constrains their exercise of choice (Holloway, 2007). More detailed examination of the issue of risk is therefore warranted.

3.4 Risk

3.4.1 Concepts of risk in welfare services

It has been argued that we are living through an epoch defined by uncertainty and this has led to a much greater emphasis on risk regulation within society (Beck, 1992), and a growing 'culture of fear' (Furedi, 1997). Since the mid-1990s risk has emerged as a significant organising principle in both public and private sector institutions. Power (2004, p.42) identifies a concern with what he calls 'the risk management of everything' within contemporary organisations. One indicator of this in health services is that while there were about 1000 citations of "risk" in British

medical journals between 1967 and 1972, in five years during the late 1990s “risk” was cited over 80000 times (Furedi, 1997).

Perhaps the most significant impact of this trend is the shift from need to risk as the central pre-occupation of social work and welfare services (Kemshall, 2002). Risk functions as a way of assessing entitlements and allocating scarce resources in the context of neo-liberal welfare reforms and the undermining of notions of universal provision (Foster, 2005). Moreover there is a fundamental inter-dependency between risk regulation and neo-liberal market economics as the shift from bureaucratic to business-oriented organisational forms requires the increasing prominence of technologies of data collection to manage risk and improve performance within organisations (Webb, 2006, p.172).

3.4.2 Risk discourse and mental health

In this context, risk discourse in mental health services has become much more prominent¹⁰ (Ramon, 2005). Processes of deinstitutionalisation are an essential component for understanding this development in the UK. The shift away from service provision for people with mental health needs in large hospitals had been a central aspect of mental health policy since the 1960s (Rogers and Pilgrim, 1996; Boardman, 2005; Lester and Glasby, 2006). This policy context was the setting for the development of the dominant risk discourse in the mental health field: that of the

¹⁰ However, this emphasis on risk is not universal and while prevalent in English-speaking countries such as England, US and New Zealand is much less so in continental Europe (Ramon, 2005).

risk posed by psychiatric patients to themselves and in particular to others (Pilgrim, 2005).

This discourse draws upon the historical stereotype existing since antiquity of the mad as dangerous (Rosen, 1978) (cited in Pilgrim and Rogers, 2003). Such discourses are then sustained by a number of intersecting factors. These include the expansion of the category of psychiatric patients to include substance users where perceptions of increased levels of dangerousness are empirically supported. Other factors include the interest work of particular powerful groups such as the media, whose selective and adverse reporting tends to portray patients as perpetrators and not victims of crime, and governments, for whom this policy direction forms part of a broader authoritarian trend under neoliberalism (Callinicos, 2000) and where little political interest accrues in challenging dominant perceptions due to mental health service users' marginal socio-economic position (Pilgrim and Rogers, 2003; Davidson and Campbell, 2007). Moreover Rose (1998a) notes a contemporary shift in the construction of this discourse. In the period before the 1960s, he argues, dangerousness is a characteristic attributed to a small minority of those within the wider category of psychiatric patients. However, by the 1990s this is superseded by a broader organising concept of risk. The latter is regarded as something inherent in the situation of all patients and requiring calculation in probabilistic terms. However, the notion that dangerousness resides exclusively within the individual should be considered a reification of risk that represents its decontextualization (Hewitt, 2008). Violent acts should instead be understood as the outcome of complex and

intersecting processes within a situational and ecological nexus (Hewitt, 2008; Pilgrim and Rogers, 2003).

There is, however, a further important element of risk discourse that is less prominent: the risk posed by psychiatric services to patients and service users.

These risks typically take the form of loss of freedom and iatrogenic risk (Pilgrim and Rogers, 1996; Pilgrim, 2005). In the following section these two dimensions of risk discourse will be discussed in the context of the development of public concerns, Inquiries and policy reform.

3.4.3 Scandals, inquiries and mental health policy

Whilst a number of factors have been cited as contributing to the push towards deinstitutionalisation (Lester and Glasby 2007), public scandal in response to the poor conditions in Victorian asylums was certainly significant (Butler and Drakeford, 2003). It was in this context that NHSCCA 1990 signalled commitment to deinstitutionalisation and officially endorsed the strategy of support for those with mental health needs in 'ordinary environments' (Barnes and Bowl, 2001). However media scandal later came to play a role in undermining public confidence in this 'care in the community' policy. The homicides committed by service users became emblematic of this policy's perceived shortcomings (Muijen, 1996; Laurant, 2003; Butler and Drakeford, 2003). Of these tragic events, two in particular impacted on the subsequent development of mental health policy. The first, the killing of social worker Isabel Schwartz by her former client Sharon Campbell in 1984, followed the latter's

frequent discharge from and readmission to psychiatric units in the context of insufficient community service provision (Butler and Drakeford, 2003). This 'revolving door' pattern (Rogers and Pilgrim, 1996) also featured prominently in the second and more high profile of the two homicides, that of Jonathan Zito by Christopher Clunis at Finsbury Park tube station in 1992. Investigations in this case also uncovered a chaotic picture of disjointed care and frequent boundary disputes between services over cost. Butler and Drakeford (2003) note that the Clunis case functioned both to reinforce public perceptions of 'stranger danger' in a risk society and popular conceptions of madness as 'alien' and 'violent', while also adding a racialised dimension to such perceptions: Clunis and Campbell are black and their victims were white. It is arguable whether these cases would have had the same public and legal impact without this latter dimension (Neal, 1998; Butler and Drakeford, 2003).

In response to incidents such as these a number of inquiry reports into homicides committed by users of mental health services were published in the late 1980s and 1990s (for example, DHSS, 1988; Ritchie et al., 1994; Appleby, 1999; Blom-Cooper et al., 1995; Blom-Cooper et al., 1996; Boyd, 1996; Crawford et al., 1997). One Inquiry report published in the wake of the Clunis case in 1996, the Confidential Inquiry into Homicides and Suicides by Mentally Ill People, has continued to collect data and produce annual reports on this topic in the intervening period (Steering Committee of the Confidential Inquiry into Homicides and Suicides by Mentally Ill People, 1996; Muijen, 1996).

However, rather than addressing the substantive policy concerns that were frequently highlighted such as inadequate levels of community provision and funding, subsequent public and political debate focused on the perceived link between violence and mental ill-health. This discourse of danger and risk was epitomised by inflammatory newspaper headlines, which have been characterised as moral panic (Paterson and Stark, 2001; Holloway, 1996; Wolff, 2002). This 'escalation' of public anxieties, served to win public support for increasingly coercive measures by the state in spite of equivocal evidence of a link between mental health problems and violence (Taylor & Gunn, 1999; Pilgrim and Rogers, 2003). As a result, in 1998 Labour Health Secretary Frank Dobson declared that community care had failed (DH, 1998).

3.4.4 Impact on professional practice

The two key approaches to defining risk and operationalizing risk work that are available to mental health practitioners are risk minimisation and risk-taking (Davis, 1996). However, in view of the role of welfare professionals in the coercive management of social problems (Pilgrim, 2012), the dominant discourses have tended to be those constructing service users as posing risks to others. As a result the risk minimisation strategy fundamentally shapes the context of professional practice. The predominant emphasis on the latter approach within services has had serious implications for the liberty and autonomy of service users (McLaughlin, 2007).

Another consequence of a greater emphasis on risk is a preoccupation with organisational accountability that results in a flight from 'expert' judgement to defensive practice. Mental health practitioners historical function has been to absorb risk on behalf of others and society more broadly (Power, 1999; 2004). An increasingly defensive mood now prevails within these occupational groups alongside an increasing pre-occupation with risks to themselves in a context of magnified media and legal scrutiny. Muijen (1996) describes an 'inquiry culture' of defensive practice, where control and risk have become increasingly central concerns for practitioners.

The publication of the inquiry reports and subsequent policy reforms reinforced to the practitioner community the extent to which they may be held accountable and criticised on the basis of their actions (Stanley and Manthorpe, 2001), and the extent to which blame was to be displaced downwards to the level of the individual practitioner (Coid, 1996) (cited in Hewitt, 2008). In the wake of this, the emergent defensive culture involved an increasing emphasis on formal procedures and training in the assessment and management of risk (Stanley and Manthorpe, 2001). Rose (1998a) describes this shift from clinical to actuarial methods in the practice of mental health professionals as the 'administrative turn'. Examples include tick-box risk pro-formas incorporated into the newly implemented Care Programme Approach (Department of Health, 1994). These reforms to service delivery procedures, as well as new legal provisions for supervised discharge served to reorient the focus of professional decision-making much more heavily towards considerations of risk, and

provoked concerns regarding the robustness of the information upon which such processes rest.

The advent of the New Labour government in 1997 did not significantly alter this trajectory within professional practice. This administration's negative evaluation of community care was soon accompanied by proposals to reform the Mental Health Act (DH, 1999a) that were highly controversial due to their paternalistic emphasis on risk management. These included prescriptions for community treatment orders (CTOs), pre-emptive detention, and increased spending on secure institutions (Szmukler and Holloway, 2000; Lester and Glasby, 2006). This policy direction was also apparent in the National Service Framework (NSF) mental health strategy published in the same year. This Framework, while nominally representing an attempt by the government to focus the system on 'evidence-based' interventions (DH, 1999b), reinforced medicalised approaches via the promotion of medication compliance as a central strategy for risk management (Bracken and Thomas, 2005). Foster (2005) links this with over-medicalisation of risky or challenging conduct, and the growing recognition of the extent to which mental health services perform a control function in the interests of third parties (relatives, public, criminal justice system) as much as providing support to service users.

Following considerable controversy and a protracted legislative process extending over almost a decade, the Mental Health Act 2007 was passed as an amendment to the 1983 Act. During this period a wide array of groups from service user networks to professional associations and trade unions under the umbrella of the Mental Health

Alliance had been ranged against the government in opposition to their plans. The predominant concern was that this legislation represented an authoritarian orientation to risk minimisation and social control rather than patients' and service users' rights, with CTOs emblematic of this (Pilgrim, 2007).

Concerns around CTOs were reinforced by a review of international evidence by Churchill et al. (2007) which found minimal evidence to support any positive outcomes associated with their use. However one notable outcome reported is increased medication compliance. As Zigmond (2011) notes, this means many service users being forced or coerced to comply with medication that they do not wish to take as part of a plan that may not have demonstrable benefits for them, raising serious ethical concerns.

There has been a significant overall increase in the number of people subject to compulsory treatment in England since these reforms were introduced in 2008 and supervised community treatment appears to be the main factor¹¹. The government significantly underestimated the extent to which CTOs would be used, with the number of orders exceeding predictions by around ten times (Lawton Smith, 2010). At 31st March 2011, the number of people in total on a CTO was up by 29.1 per cent on the previous year to 4291, and the overall number of people subject to the Mental Health Act increased by 5 per cent (The NHS Information Centre, 2011). This bears out the fears of opponents of reform regarding their authoritarian dimension, and serves to reinforce stigmatising perceptions of mental health service users as posing

¹¹ This is part of a broader coercive trend in mental health services exemplified by the increase from approximately 19 000 formal compulsory admissions to hospital in England under the MHA in 1987/88 to just under 50 000 by 2000 (Zigmond, 2011).

a danger.

3.4.5 Risk and responsibilisation in mental health practice

In section 3.3.3 the concept of responsibilisation was introduced. This perspective enables exploration of the apparently contradictory relationship between the policy rhetoric of service user involvement noted above and the contemporary preoccupation with risk management.

As noted earlier, Brown and Baker (2012) identify an increasing emphasis, supported by many users, towards individual strategies of self-management both of mental health and risk factors. From a libertarian perspective, these trends are regarded as welcome insofar as they represent a reduction in paternalistic and authoritarian intervention by mental health professionals licensed by the State to engage in forms of social control (Pilgrim, 2012). Moreover such critics have also argued that the interest work of some institutions of left collectivism, for instance trade unionism, may constitute a barrier to the realisation of self-determination through individualised mechanisms such as direct payments (Spandler, 2004).

However others contend that it is, in fact, neoliberalism that is driving welfare policy towards a penal approach (Wacquant, 2001; Brown and Baker, 2012). Rather than license welfare interventions to manage the social and psychological impacts of, for instance, the increased poverty and inequality generated by neoliberal economic policy, there is a tendency to turn to penal solutions or to reconfigure welfare services

so that their policing and social control functions are more prominent. In this context making service users more 'responsible' for their actions provides ideological justification for punitive sanctions towards those who are unable or unwilling to do so. The marginalisation of the role of social determinants in relation to mental health and distress is an essential component of this reconceptualisation of accountability that positions the individual mental health service user as fully liable for their actions regardless of their mental state. A rise in the numbers of those with mental health needs incarcerated in prisons bears witness to this trend (Durcan, 2008; Brown and Baker, 2012).

For Warner (2007) this coercive and risk focused orientation typifies the recent direction of mental health policy and, paradoxically, serves to undermine other initiatives seeking to challenge and address the impact of stigma and social exclusion of people with mental health needs. Warner describes this phenomenon as 'structural stigma' to emphasise its policy and organisational aetiology. There is scant evidence for the effectiveness of such risk minimisation strategies, either from a predictive or preventive perspective, and an alternative approach concerned with widening access to mental health services would appear to provide a safer option for both users and the public (Munro and Rungay, 2000).

3.5 Chapter summary

To conclude, this chapter has provided an overview of the literature in relation to some key themes for understanding professional practice in the field of mental health.

This has included the labour process that organises the practices of occupational groups within this field and the interprofessional and managerialist context of mental health work. The chapter went on to consider three additional structural features that are reshaping practice in the mental health field: interprofessional working, user involvement and risk. It was argued these dimensions interact in complex ways with the broader neoliberal reconfiguration of welfare services and society.

My argument in the thesis will be that these various contextual features should not be considered as analytically distinct but as interacting in a dynamic totality that shapes not only the activities of practitioners but their ways of thinking. Therefore, having provided an overview of some of the models of mental distress informing practice in Chapter 2, and the structural and policy context of the activity of practitioners in the present chapter, the thesis will go on, in Chapter 4, to propose a theoretical framework for understanding the field which combines these elements: forms of knowledge, the practices of mental health workers and service users and the systemic context of their activity into a model that articulates the dynamic relationships between them.

4. THEORETICAL POSITIONING

4.0 Introduction

This chapter will provide an overview of the theoretical positioning of the thesis. The starting point will be a critique of the *Models Project* (Fulford and Colombo, 2004) briefly introduced in the previous chapter. It will be argued the approach in that study represents an exemplar of dominant static notions of knowledge in the mental health field. Instead I will propose an alternative framework utilising the resources of critical realism.

The chapter will start with an epistemological critique of the Models Project. The notion of a laminated system will be deployed to develop a more dynamic analysis of the relationship between knowledge and the spatio-temporal context of action. In the second part of the chapter it will be argued that the notion of mental health services as a 'pentimento'¹² developed by Rhodes (1993) provides a suitable spatio-temporal framework for developing a contextually situated account of the knowledge and activity of practitioners and service users within this field. The pentimento will therefore be described in detail. However, in order for this framework to be consistent with the critical realist position of the thesis it will be argued that significant epistemological reconstruction is required. Therefore an adapted pentimento

¹² *Pentimento* describes an underlying image in a painting that shows through when the top layer of paint has become transparent with age, and is used metaphorically by Rhodes (1993).

incorporating both diachronic (spatio-temporal) and synchronic (including micro-macro scale) analytical considerations will be proposed in the third section of the chapter. A diagram of this reconstructed pentimento is located in Appendix 3.

The adapted conceptual framework outlined here should be understood as provisional. The assertion of this chapter is that this model is an appropriate tool for developing a dynamic understanding of the relationship between concepts and the context of action in mental health practice. However the data utilised to justify this theoretical reconstruction will not be presented until the detailed case studies and examples from fieldwork in Chapters 6, 7 and 8. Having marshalled and analysed this evidence from the field there, Chapter 9 will return to theoretical considerations and demonstrate how the data from the study was used to reconstruct the pentimento.

This process of theoretical reconstruction is informed by the ‘adaptive theory’ methodology developed by Layder (1998) where both prior conceptual frameworks and the data generated during research contribute, in an iterative process, to the development and elaboration of new theory. This methodological approach will be discussed in detail in Chapter 5. However the presentation of the reconstructed pentimento in this chapter necessarily involves collapsing this iterative procedure into a more linear form for the purposes of clarity. Having provided these clarifications the chapter will now return to discussion of its substantive topic.

4.1 Models project

The Models Project (Colombo et al., 2003) usefully illustrates the way in which frameworks or models for understanding mental distress/illness are commonly conceptualised within mental health services and associated academic departments. The Models Project was conceived in order to investigate 'problems' around communication and consistency of approach within integrated multidisciplinary mental health teams. This study has been influential with the findings published in a number of academic journal articles and edited volumes (including Colombo et al., 2003; Fulford and Colombo, 2004; Colombo, 2008). Moreover, the project has also informed the development of an approach to frontline practice known as *values-based practice* (Woodbridge and Fulford, 2004; CSIP/NIMHE, 2008) that seeks to address conflict within mental health teams.

The Models Project approach begins from the premise that decision-making in multidisciplinary mental health teams is negatively affected as a result of conflicts generated by differing implicit models of mental distress/illness held and utilised by service users, informal carers and the various professional groups in this field. The implicit models identified within the study derive from six formal models of mental disorder proposed by the authors following a review of the relevant literature. These models are the medical (organic), social (stresses), cognitive-behavioural, psychotherapeutic, family, and conspiratorial models (Colombo et al., 2003). These *explicit* formal models serve as ideal types and are used as a reference point to enable identification of, and comparison with, the *implicit* frameworks articulated by

practitioners and users (Colombo, 2008). The team then developed a models-grid to illustrate these six explicit ideal type models, featuring twelve key elements of each including diagnosis/definition, aetiology, treatment modalities, etc.

4.1.1 Models project: an epistemological critique

While the notion of implicit frameworks acknowledges the tension between models as formal knowledge and their application in the practice context, nonetheless the data for the Models Project study was drawn from interviews with practitioners and users exploring their responses to a case vignette. The analysis of these data involved coding participants' understandings of mental distress/illness as represented within the vignette in terms of their agreement with a Models-grid based on the six formal models identified above.

However there are epistemological problems inherent in this approach.

Approximating implicit to formal models represents a tendency towards a static, reified notion of knowledge, where models are conceptualised as a 'thing'. It will be argued here that a more *contextually situated* account of models (knowledge) in use in the field is necessary in order to illuminate the complex array of formulations articulated in practice to explain experiences identified as mental illness/distress. To develop this argument an epistemological detour will be required in order to explore some misconceptions about knowledge.

4.2 Critical realism and knowledge

A starting point for understanding knowledge in critical realist terms is that CR looks beyond the surface appearance of events to try and understand the underlying causal mechanisms generating them. In applying this to an object such as natural science, it would be recognised that science is about something that exists independently of scientific enquiry. At the same time the 'work' of science involves the transformation of already existing sets of theories into deeper knowledge of the world. Leading critical realist theorist Roy Bhaskar labels this the 'two sides' of knowledge, using the terms *transitive objects of knowledge* for the facts, theories and models developed to explain the world, and *intransitive objects of knowledge* for the things that this knowledge is 'of', but which are not dependent on human activity (Bhaskar, 2008a; Collier, 1994).

This perspective contends that knowledge is always embedded in social practices Sayer (1992). Though knowledge may be furthered through passive contemplation, the contexts of *labour* and *communicative interaction* are presupposed as individuals cannot develop knowledge independently of a society in which they can learn to think and act. Bhaskar (2008b) extends this notion of context to encompass four planes of social being: knowledge is generated through activities constituted by i) material transactions with nature; ii) social interactions between agents; iii) social relations and institutions, which includes pre-existing canons of knowledge (social structure) and iv) the stratification of embodied personality.

In examining knowledge and practice it is, however, important to move away from a dualistic conception of their relationship. Knowledge has a contextual dimension insofar as its development requires activity within the planes outlined above rather than mere contemplation. Thus knowledge and practice are in an interdependent and not dualistic relationship. We do not need to be aware of the names of concepts to have them: conceptual systems concern not only what we can observe but what we can do and how we can do it.

This highlights a broader and basic distinction that derives from the work of Gilbert Ryle: between *knowing that* (propositional knowledge) and *knowing how* (practical knowledge). Practical knowledge is that which is needed by the agent in order to act in the world but which may not be codified as such by them, because knowing how to perform a skill does not necessarily require propositional knowledge about it (Polanyi, 1958 and Ryle, 1949) (cited in Bhaskar, 2008b). Propositional and practical knowledge are necessary for any action but these operate on different levels and should not be confused.

The implication of this for particular fields of professional practice such as mental health social work¹³ is that practitioners and their practice cannot be reduced to propositional knowledge. Through their strategic efforts, practitioners produce *contextually situated knowledge* - a concept drawing on notions of tacit knowledge and practice wisdom¹⁴. This contextually situated knowledge might include getting a

¹³ The social work profession will be utilized to provide illustrative examples but the general arguments could be applied to other occupational groups in the mental health field.

¹⁴ Bhaskar (2008b) argues that practical wisdom involves the integration of knowledge in the light of values, as part of four-fold schema of data, information, knowledge and wisdom.

‘feel’ for the *application* of codified knowledge, the tacit or implicit dimensions such as ‘bedside manner’, or knowledge of the case and its context. Contextually situated knowledge might also involve that which is particular to certain domains, for instance how things work in a type of mental health team or service in the UK, which will be different again from comparable teams in another country; or another example is disability social work where the recommendation of the use of types of hearing aid involves questions that are partly technical – knowing what works for people, but also partly political, e.g. cochlear implants might be seen by some to impede flourishing in their identity as a disabled person, and thus knowledge is context specific.

However, it is necessary not only to distinguish practical or contextually situated from propositional or theoretical knowledge but also to make a further distinction between two types of codified or theoretical knowledge. In the first, social work knowledge includes material drawn from disciplines such as sociology; the second is applied knowledge drawn from the field and then codified, for instance discourse about practice wisdom and theory concerning the acquisition of skills. An example of the latter is the strengths perspective (‘strengths case management’), the formal knowledge base for much community mental health practice in the US. Floersch (2002) notes that is based on a codification of the situated practices of case managers during the 1980s to produce the ‘strengths’ practice model. In this sense health and social care professions should be understood as craft work, requiring competencies utilising contextually situated and applied knowledge as well as formal theoretical knowledge.

In applying this CR framework to the activity of health and social care professionals in multidisciplinary mental health teams, formal theoretical knowledge takes the form of the various models for practice (e.g. medical or social models) typically identified with different mental health professions. Floersch (2002) argues that such theoretical models (which he frames in Foucauldian terms as disciplinary knowledge) constitute a basic component of the conditions for professional practice. The second type, applied knowledge, takes the form of local policies and formalised ways of working shaped by team requirements and experiences, for instance the ART assessment model adapted by team members in one of the community mental health teams (CMHT) studied¹⁵. The third form of knowledge, the contextually situated, refers to the specific, local and contingent forms of knowing produced in everyday practice and not mediated by formal theory (Floersch, 2002). These types of knowledge can be understood as generative mechanisms as they are causally efficacious. Because such causal tendencies are co-determined in open systems, the actual outcome of a tendency will depend on the activity of other mechanisms in relation to it (Bhaskar, 1998).

4.3 Laminated systems: a critical realist alternative

As well as the detailed elaboration of context required to develop a sufficient understanding of knowledge in a field such as the mental health team, the multiplicity

¹⁵ Southville CMHT was the site of a pilot study of the Acute Response Team (ART) model within the Trust. The ART is a model for organising the management of referrals to the CMHT, which involves two dedicated full-time workers. The main function of ART is to take referrals, carry out initial assessments and refer on those assessed to the appropriate service. This replaces a system of rotating 'intake' duties amongst CMHT members.

of professions necessitates an interdisciplinary focus. Bhaskar (2010) explains this as follows. In critical realist terms the phenomena of the social world occur in open systems and thus the complex co-determination of such phenomena requires a conception of reality as comprised of multiple distinct mechanisms operating at a number of emergent and interacting levels. This conjunctive multiplicity is referred to as a laminated system or totality.

There are various kinds of lamination and these are irreducible to their components. Bhaskar (2010) goes on to identify four¹⁶ but, for the purposes of constructing a theoretical framework for the thesis, two types of laminated system are of particular relevance: laminations of scale and spatio-temporal emergence. These will assist in developing an understanding of the interplay of causal mechanisms, contexts and effects in operation at different levels of reality that contribute to the various modes for understanding mental distress in the setting of the community mental health team. These will now be outlined and their contribution to an analytic understanding of knowledge within the field of the mental health team briefly assessed.

The first, lamination of scale, refers to the operation of causal processes at levels from the sub-individual psychological to the mega level of mechanisms at a global scale. This conception of levels of scale enables a synchronic perspective on such processes. Three levels of scale have been identified as particularly apposite to this study: the micro (interpersonal interactions within teams), meso (occupational and organisational processes) and macro (the political economy of the welfare state).

¹⁶ Bhaskar (2010) notes laminations of level, plane, scale and spatio-temporal emergence.

This draws on and adapts both the work of Porter (1995) and of Pilgrim and Rogers (1999b).

The second form of laminated system, spatio-temporal emergence, describes the processes of historical sedimentation of ideas or institutions that take place over time, and will adapt the notion of the 'pentimento' proposed by Rhodes (1993). This will facilitate a diachronic perspective. The integration and interaction of these two types of laminated system will provide, it will be argued, an explanatory framework that incorporates some of the most significant forms of causality in operation within this domain over time and at different levels of scale from micro to macro (Bhaskar and Danermark, 2006). These two forms of laminated system will be elaborated in greater detail in the following sections.

4.3.1 Laminated system of scale

The development of the laminated system of *scale* for this study was aided by Porter's (1995: 160) ethnography of nurse-doctor relationships in which he proposed five relevant levels of scale. These are as follows: (i) social structural (the political economy of neoliberalism and its impact on the healthcare sector); (ii) occupational (disciplinary/theoretical knowledge and professional cultures, interprofessional relations/division of labour); (iii) organisational (managerialism and the reconfiguration of occupational roles); (iv) situational (including contextually situated knowledge); and (v) individual (the contingent nature of individual actors and action). Whilst Porter's study examines the domain of general nursing and medicine, it will be

argued that all of these levels are relevant to an understanding of knowledge in the context of mental health practice.

However, following data analysis and in the interests of theoretical parsimony, this was reduced from the five-tier to a three-tier model. This drew on the analytic framework for mental health policy articulated by Pilgrim and Rogers (1999b). Integrating the latter model with that of Porter produces *macro level*: political economy shaping the particular form of the welfare state, e.g. neoliberalism or Keynesianism; *meso level*: occupational and organisational processes; and *micro level*: individual and situational. The interaction of the generative mechanisms operating at each of these ontological levels serves either to accentuate or attenuate the effects of those at others, and due to the open systemic nature of the social world of the community mental health team the outcome of such combinations of mechanisms is a matter for empirical examination.

4.3.2 Spatio-temporal laminated system

With regard to *spatio-temporal* lamination, analytical and theoretical development was influenced by two primary sources. The first is Bhaskar's (2008b: 164) conception that communicative interactions and practices are enacted within 'differentially sedimented structural institutions' which shape rhythmicity such as the flow of the working day and workplace tasks. The second is an ethnographic study by Rhodes (1991; 1993) that constructs the mental health unit as a differentially sedimented institution. Here, it is argued, clinical practice in the psychiatric unit

should be understood as a process involving movement between overlapping and co-existing layers of historical meaning, utilising the metaphor of the *pentimento* - an underlying image in a painting that shows through when the top layer of paint has become transparent with age - to conceptualise this. In Rhodes' study each level of this layered domain is associated with historically specific forms of institution and practice. In the following section this schema and its role in the development of the conceptual framework of this thesis will be set out in more detail.

4.4 The pentimento: a conceptual framework for knowledge and practice

In her ethnographic study of a US psychiatric unit, Rhodes (1993) draws on Schon (1983) to argue that the 'high ground' of research based theory and technique is often felt to be of little relevance to practitioners and service users who are immersed in what Schon calls the 'swampy lowland' of everyday situations, challenges and concerns. Rhodes (1993) argues that theory-based models of mental distress may be of limited utility in understanding the unfolding of events on the ground and proposes a 'situational understanding' based on an analysis of the relationship between concepts, actor and the systemic context of action.

4.4.1 The pentimento: gesture

Rhodes (1993) argues that action by practitioners should be understood as what she calls *gesture*, rather than simply in terms of a formal account of the professional or institutional role. This seems to have some parallels with Goffman's notion of front

and backstage behaviour (Goffman, 1990). She notes there is a contradiction and tension between the *public face* of the institution (formal presentations, policy, case records/conferences) and the *practical orientation* of staff within it. For instance, she notes that while the formal account of the work of the unit concerns treatment, in its practical orientation the most basic concern is the discharge of patients. An example is one discussion that, though formally concerned with diagnosis of a patient, was underpinned by the need to make a decision about where to accommodate this person in the community. Rhodes argues that the 'primary gesture' of disposal thus subordinates other gestures like diagnosis, or in other words that diagnostic decision-making was strategically oriented towards community placement. This also highlights the way in which the gesture of 'disposing of' mimics production processes with emptying beds and efficiency as its goal (Rhodes, 1991).

4.4.2 The *pentimento*: strata

In addition to this idea of the strategic orientation of action, Rhodes' other key proposal is that clinical practice should be understood as a process involving movement between overlapping and co-existing layers of historical meaning, using the *pentimento* metaphor. She recommends beginning from a focus on practice in its historical context rather than overemphasis on current concepts and reforms, and then introduces the idea of psychiatry as a historically layered domain. Each of these layers is associated with particular forms of institution and practice. This Foucauldian archaeological approach to the mental health field posits three key historical moments, beginning with the most fundamental, that of confinement or the asylum;

then moving forward to the biomedical or psychotherapeutic gaze which identifies the underlying problem and its appropriate treatment; and following this, the systemic approach underpinning community psychiatry and de-institutionalisation. The following section will outline these three historical layers in greater detail:

Confinement

Rhodes (1993) draws on Foucault (1977) to argue that the earliest, harking back to the eighteenth century, is confinement within the asylum. This setting is a place where those considered 'mad' are confined and excluded from society while at the same time constructing them as an object of psychiatric knowledge.

The Biomedical Gaze

A more recent layer is that of the biomedical gaze. This has two aspects: the first is the medical gaze which penetrates the body, from the CT brain scan to the drug study in which brain pathology underpins psychotic experience. The second is the psychodynamic gaze which peers through the utterances of the patient to locate pathology within the psyche. Whilst these approaches are diverse, in mental health settings they share the implication of seeking an 'underlying' problem upon which medication or psychological intervention might act.

Systemic/Community approaches

The systemic or ecological approach is the most recent stratum and emerged in the 1950s. It looks beyond the body to the external environment and in so doing expands the medical gaze. From this community psychiatric perspective, the task is to

understand the context of the patient's problems in terms of family, employment or previous institutionalisations. This enables the patient to be placed in the appropriate ecological niche.

Rhodes's psychiatric pentimento is not, however, a static model but one in which these older and newer conceptions of doctor/practitioner and patient/service user are entangled and interwoven. The strata are conceptualised as ideological positions that co-exist within practitioners as alternative modes of thinking, and operate in a relationship of tension to one another.

4.4.3 The pentimento: summary

With this combination of historically stratified meaning and gesture (action), Rhodes' pentimento forms a dynamic picture. She finds skill resides not just in diagnosis but an ability to move strategically between these layers of meaning. Moreover, as these contexts implicate objects with contradictory needs – patient/service user, society and community – she notes that the really skilled practitioner is one who has the capacity to manoeuvre between them and take action appropriate to the circumstances they encounter. Thus the gestures of mental health practice “must be learned in context and through action, with skill dependent upon sensitivity to the situation” (Rhodes, 1993, p.137)

Rhodes (1993) concludes that the training of practitioners tends to ‘thingify’ (with nouns like diagnosis, treatment, aftercare), but to be an effective practitioner requires

reflection on doing – how one practices. The place (e.g. the unit) provides the ground for action it cannot be abstracted and turned into a ‘map of all possible routes’ (Bourdieu, 1977) (cited in Rhodes, 1993). Thus each reform creates a new layer of practice, and though old layers do not go away nor do the new achieve full coverage. This produces a field of contradictions that are acted out in practice, involving continuities with past but also disjunctions.

4.4.4 Extending the pentimento framework

Rhodes’ two key proposals, the notion of layered meanings and a focus on the strategic use of concepts in action, provided considerable analytic purchase on the data collected in the course of this study. The detailed and iterative process of analytic work and development of adaptive theory will be described in Chapter 5. However, as a result of this work the theoretical framework of the pentimento was adapted to incorporate an additional neoliberal stratum, reflecting institutional reconfigurations of the mental health field in the UK over the last thirty years. This stratum has three dimensions: *i) marketisation of services, ii) risk and coercion and iii) service user involvement and consumerism*. This additional layer will be outlined in greater detail in section 4.5.3.4 below. However it is first necessary to continue with the epistemological reconstruction of the pentimento framework.

4.5 The pentimento and critical realism

Rhodes’ notion of a historically layered domain and practice as gesture is broadly

consistent with critical realist epistemology. Nonetheless the Foucauldian archaeological approach that she utilises created some tensions for a realist approach. However this period in Foucault's work is probably the one in which there are the closest parallels between the two meta-theoretical positions because, like critical realism, "archaeology... reveals relations between discursive formations and non-discursive domains (institutions, political events, economic practices and processes)" (Foucault 1989, p.162) (cited in Joseph 2004, p.146). As such, therefore, Foucault does not simply reduce reality to discourse, a tendency apparent in some of his later work. But, while the archaeological framework does offer some account of structure, this remains of a more discursive nature, and leaves little room for human agency. As van Heur (2008, p.46) notes, there is a problem of 'discursification' of history, whereby a concern with representation analytically marginalizes the structuring role of historical trajectories on contemporary actions. Thus Foucault's social ontology is one characterised by dispersion, contingency and fragmentation, lacking depth and a coherent account of stratification (Joseph, 2004). The strength of a critical realist approach is that, by contrast, it provides an account of social structure as relatively enduring (continually reproduced and occasionally transformed) but dependent on human activity and conception of that activity. It is for this reason that Rhodes' pentimento required a critical realist epistemological reconstruction to integrate an account of the relationship between agency and structure. This will be elaborated in the next section.

4.5.1 Reconstructing the pentimento 1: theorising agency and structure

As noted above, theorists working within the critical realist paradigm have developed extensive theoretical resources for conceptualising the relationship between human agency and social structure, which avoids the reification of either knowledge or the social (and material) context. Archer (1995) and Callinicos (2004) offer complementary accounts framed within this socio-historical materialist tradition.

Archer's morphogenetic approach places sociological understanding within a historical context, and provides a theoretical perspective on the structuring of social systems over time. This temporal interaction between structure and agency involves a three stage cycle: "(a) structural conditioning, (ii) social interaction and (c) structural elaboration [or transformation]" (Archer, 1995, p.89). As she notes,

Structure and action operate over different time periods – an assertion which is based on its two simple propositions: that structure necessarily predates the actions which transform it; and that structural elaboration necessarily post-dates those actions. (Archer, 1995, p.89-90)

This account is consistent with that of Bhaskar (1998) who argues for an understanding of social structure as relational, and conceptualises social roles as networks of 'positioned practices'. These positioned practices and their inter-relationships pre-exist their occupation by particular individuals. An account of the nature of the structural positions that enable and constrain the activity of agents is provided by Callinicos (2004, p. xxiii) who describes social structure as:

[A] relation connecting persons, material resources, supra-individual entities (social institutions of some kind), and/or structures by virtue of which some persons (not necessarily those so connected) gain powers of a specific kind.

However these theorists are careful to note that while social interaction is structurally conditioned it is never structurally determined because of the irreducible emergent powers of social agents.

An account of discourse must also be incorporated. Social worlds are concept dependent, and thus the elements elucidated in this schema can be developed to include an account of the relationship between the discursive and extra-discursive aspects of social being, in particular the way in which the former is both constitutive of and conditioned by, and in turn conditions the latter (Bhaskar, 2010, p.10). This is rooted in the assumption that language is an irreducible element of social life, but is in a dialectical relationship with other elements of the social world, and thus while analysis must take account of language, the social world cannot be reduced to it (Fairclough, 2003).

The aim of the above discussion is to offer a theoretical framework for understanding the emergence of forms of knowledge and practice in the mental health field within particular institutional and historical contexts. This account based on the morphogenetic approach of Archer offered a firmer ontological foundation for the understanding of spatio-temporal emergence within the CMHT than provided by Rhodes' (1993) pentimento. In this account the ideological strata of the pentimento can be understood as the generative mechanisms associated with various co-existing and historically sedimented institutional forms within the mental health field. Rhodes' (1993) work demonstrates a conception of the contextual and temporal dimensions of knowledge as advocated above by Sayer (1992). Moreover, at each

new layer the tension between this tendency to 'thingify' and action as gesture echoes the interaction between disciplinary and contextually situated knowledge (Floersch, 2002).

Having described the theoretical groundwork required for the reconstruction of the pentimento, the next section will develop a socio-historical materialist account of the development of welfare services in England. Rhodes' account draws on fieldwork in the US and thus further adaptation of this model was necessary in view of the differences in the historical trajectory of mental health service provision between the two jurisdictions.

4.5.2 Reconstructing the pentimento 2: developing a socio-historical account of welfare service provision in England

A number of theorists have provided accounts of the development of mental health or welfare service provision that demonstrate the value of a socio-historical perspective. For instance McDonald (2006, p. 3) argues that the ideas and practices of social work are the result of "the gradual accumulation of past practices and understandings... which have gradually taken on a (more or less) 'accepted' status". She notes that the activity of this occupational group is shaped by the particular institutional arrangements of the welfare state system in which it is embedded and upon which it is dependent. For McDonald et al (2003), the historical reconfiguration of welfare regimes and the consequent reconstitution of professional practices is the outcome of broader economic, political and ideological processes.

Similarly, for Busfield (1986, p.8) psychiatry should be understood in its historical context as current ideas and practices are shaped not only by contemporary social conditions but also by the traces of past thought and action. In explaining this process of social and historical constitution, she notes an association between changing conceptualisations of mental illness and distress and the stages in the development of forms of mental health service provision. These ideas and practices, Busfield argues, are shaped by the activity and interaction of two key agents: the medical profession and the state.

While Rogers and Pilgrim (2010, p.11) too describe the mental health field as one in which sedimented layers of (sociological) knowledge overlap unevenly in both time and across professional and disciplinary boundaries, the particular nature of the conditions and pressures which, at any one conjuncture, produce these sedimentations requires further exploration. Harris (2008) utilises the notion of 'conjunctural settlement' to describe the predominance of certain discourses during a particular period or 'moment'. However, he acknowledges that at each 'moment' multiple alternative though subordinated ideas and practices are present as forms of resistance to dominant ideologies, oppositional tendencies that challenge hegemonic ideas (Coppock and Hopton, 2000). Nonetheless, for Harris (2008), each newly emergent conjuncture does not fully supersede but imbricates traces of earlier thought and action.

The role of social struggles and resistance in shaping welfare settlements in England

at particular historical conjunctures has been recognised by a number of social policy theorists (Creaven, 2000; Ferguson et al., 2002). One such socio-historical materialist account is developed by Sedgwick (1982). He challenges reductionist explanations for the shift from institutional to community care of the post-war period such as the notion of a 'pharmacological revolution', or the fiscal crisis of the state hypothesis advocated by Scull (1977). While the economic context is important, he argues, this mechanism is relevant insofar as it underpins particular general systems of public welfare assistance. Thus the Victorian asylum should be understood as developing in relation to the broader Poor Law workhouse system, while the contemporary mental health day centre presupposes forms of Keynesian public welfare to maintain income in the community. As such then, the particular ideas and practices of mental health services during any epoch implicate structural and political pre-conditions. Transformations in the form taken by mental health systems are realised when new conditions of political possibility emerge linked to particular collective social agents and ideological tendencies.

4.5.3 Reconstructing the pentimento 3: spatio-temporal emergence of mental health systems

Drawing on Harris (2008) and Sedgwick (1982), a conception of conjunctural welfare settlements as enabled and constrained by conditions of structural and political possibility was utilised to reframe Rhodes' three pentimento strata: confinement, the biomedical gaze, and the systemic approach. Adding the additional stratum noted in section 4.4.4 above, four key 'moments' in the history of mental health services in

England were developed: the custodial system of the asylum, the biomedical treatment system of the hospital, community care within the Keynesian welfare state, and the neoliberal reconfiguration of services. These will now be outlined in detail.

4.5.3.1 The custodial system

Challenging the argument presented by Foucault (1961) concerning the mid-seventeenth century 'Great Confinement' across Europe, Rogers and Pilgrim (2001) identify only a small-scale development of 'madhouses' in Britain during this period. It was not until the early nineteenth century that a more widespread centralised and segregative public asylum system emerged (Porter, 1987) (cited in Rogers and Pilgrim, 2001). The state's adoption of a more interventionist stance with regard to madness during this period was apparent in several pieces of legislation such as the 1828 Madhouse Act and shortly after the 1845 County Asylums Act and Lunacy Act of the same year. Moreover comprehensive data on lunacy became available for the first time with the 1844 Report of the Metropolitan Commissioners in Lunacy. The growth of state involvement in this arena was particularly directed at 'paupers' and formed part of a wider reform of the Poor Law system marked by the 1834 Poor Law Amendment Act (Rogers and Pilgrim, 2001). The context of these reforms was the social and economic convulsion produced by an escalated process of land enclosures and the pauperisation of the working class that accompanied and drove the development of capitalism in the context of the Industrial Revolution (O'Brien, 2000).

At this time the predominant form of practice within the asylum system was custodialism (Rogers and Pilgrim, 2001). Conditions were influenced by the wider context of the barrack-like regimes of the new sites of industrial production, the factory and mill, and the environment of their alternative: the workhouse (O'Brien, 2000). The design of the buildings reflected this and, in spite of grand facades, inside modelled prisons both in terms of the concern with security and in the culture of the staff (Busfield, 1986). The 1890 Lunacy Act served to reinforce this custodial orientation. Although an alternative conception, that of 'moral' treatment developed in the previous century by Quaker William Tuke at the York Retreat and underpinned by a therapeutic 'normalising' regime, was available at this time it was marginal to mainstream practice within the asylum system. Similarly, rudimentary biological ideas that emphasised the genetic inferiority of asylum inmates, though prevalent, did not lead to forms of intervention that could advance the profession of medicine's claims to provide cures and elevate its status as a medical specialism (Rogers and Pilgrim, 2001).

4.5.3.2 The biomedical treatment system

The period from the late nineteenth century to the first half of the twentieth century saw a significant growth in state intervention around social policy (Lavalette and Penketh, 2003). These policy initiatives included the areas of public health, housing schemes for the working class, social insurance and pensions schemes. A particular focus in the early twentieth century related to health and welfare interventions and these broader developments have been linked to forms of emergent collective social

agency such as the 'New Unionism' in interaction with ruling class requirements for a healthy workforce in the fields of both production and military preservation of Empire (Charlton, 2000).

Alongside this, a challenge to the institutional containment strategy of the asylum in the Victorian era emerged during the first half of the twentieth century. In 1915 The Maudsley Hospital in London opened, followed only five years later by the Tavistock Clinic, and this formed part of a significant expansion of psychiatric hospital and outpatient clinic provision (Coppock and Hopton, 2000). This was driven in part by the prevalence of shellshock during the First World War, and also served to undermine notions of genetic inferiority as this condition affected middle class officers as well as working class soldiers. A new emphasis on the role of the environment developed and this saw a growth in influence of psychodynamic and psychological ideas and treatments amongst some medical practitioners. However their influence was still limited by the extent of their main setting, the sphere of private practice, which remained relatively marginal within the UK in contrast to the US (Busfield, 1986).

The 1924-6 Royal Commission on Lunacy marginalised asylum doctors from its deliberations, but the outcome represented both continuity and change for the asylum system. Influenced by the above factors, the recommendations promoted a new emphasis on medical care and cure but also legitimised the deprivation of liberty of those deemed mentally ill. These dimensions were carried forward into the 1930 Mental Treatment Act, reinforcing both the role of the medical profession and the

asylum alongside an emergent treatment rhetoric enacted via a range of somatic interventions such as paraldehyde, laxatives, chloral hydrate and later insulin coma, psychosurgery and electroconvulsive therapy (Rogers and Pilgrim, 2001).

While the 1930s had heralded a shift in institutional practices and ideology towards new forms of biomedical treatment, the 1950s saw a more fundamental shift in terms of developments within pharmacology. This involved the introduction of new neuroleptic medications such as Haloperidol and Chlorpromazine, the so-called 'anti-psychotic' treatments (Healy, 2002). This provided a backdrop to the 1957 Royal Commission (the Percy Report) and subsequent Mental Health Act 1959 which reinforced as the dominant conception that mental disorder was a form of illness that was amenable to biomedical treatment following identification and diagnosis by psychiatric practitioners (Rogers and Pilgrim, 2001). However, whilst biomedically-derived concepts and practices were in the ascendant during this period, the asylum system from the Victorian era in which they were still predominantly enacted was entering a period of crisis.

4.5.3.3 The community care system

In the post Second World War period a new welfare consensus was emerging. This welfare settlement was the outcome of an uneasy alliance between state monopoly capital and the labour movement as their interests converged around the construction of the Keynesian welfare state (Creaven, 2000). Busfield (1986) notes that the development of novel forms of welfare provision created a context in which

new approaches to the community treatment of the mentally ill became both acceptable and feasible.

Hospitals for mental illness were reorganised to integrate with the new welfare state structure as part of the National Health Service (NHS). However it was not until the 1962 Hospital Plan announced by Minister of Health Enoch Powell in his earlier 'water towers' speech that the move from asylums to community care began to take shape¹⁷. Here the role of acute treatment in District General Hospital (DGH) units was to supersede care in the asylum alongside new community provision. Alongside this, two key provisions in the 1959 Mental Health Act further facilitated the development of community services, a requirement for outpatient follow up of patients who had been discharged after detention, and the legislated role of social work (Lester and Glasby, 2010). However while the DGH units began to increase in number this was not matched by an expansion of community care facilities (Rogers and Pilgrim, 2000). There was some increase in provision of psychiatric services in primary care, but a lack of investment in residential facilities by local authorities as a result of their competing funding obligations prevented more extensive community provision (Busfield, 1986). Furthermore it has been argued by Scull (1977) that a fiscal crisis of the state undermined the development of this policy, though this hypothesis fits the 1970s better than the period of 1950s to 1960s proposed (Rogers and Pilgrim, 2001).

¹⁷ However the policy discourse of community care was present in the 1926 Royal Commission and 1930 Mental Treatment Act noted above (Pilgrim, 2009).

Nonetheless a new institutional network of community mental health service provision had emerged by the 1980s as the last of the asylums moved towards closure. These included, alongside the DGH units, community residential facilities such as hostels, group and nursing homes, and NHS and social services-run community mental health and day centres (Rogers and Pilgrim, 2001). Associated with these developments is the involvement of a much wider range of occupational groups, such as social work and psychology, with knowledge bases that fall outside of the boundaries of that of the psychiatric profession. The challenge to the authority of psychiatry resulting from these changes has been contained as a result of the subordinate role of these groups within a medical hierarchy (Busfield, 1986).

4.5.3.4 The neoliberal market system

The Keynesian welfare consensus and the notion of the state as a vehicle of social reform began to come under sustained critique from the New Right from the late 1970s onwards (Ferguson et al., 2002). Social democratic perspectives in favour of state intervention in areas such as health and social care have been superseded by a neoliberal conception, which considers the proper role of the state to be one of facilitation of free markets rather than direct provision of services (Harvey, 2005). It was noted in section 4.4.4 that the emergence of this neoliberal stratum and subsequent organisational and occupational reforms to the mental health field since the early 1990s has three dimensions: *marketisation of services, risk and coercion* and *service user involvement and consumerism*. These will be elaborated in the following sections.

4.5.3.4.1 Marketisation of services

Chapter 3 noted that while many sectors of the economy were subjected to neoliberal reform during the 1980s, the impact of the market on mental health services was relatively marginal until the 1990 NHS and Community Care Act (NHSCCA).

However this Act constituted a major turning point, leading to the marketisation of the health and social care sector and profound changes in the nature of welfare work.

This section will draw on the arguments of Harris (1998; 2003), Law and Mooney (2007; 2008) and Player and Leys (2008) presented in sections 3.1.2 and 3.1.3 above to elucidate the marketisation dimension of the neoliberal stratum.

Whilst the purchaser/provider split implemented from 1993 was perhaps the most significant feature of marketisation (Harris, 2003), the process of transition to the market has several prominent elements. Of particular relevance to the mental health field are: service commodification and standardization (e.g. care pathways and mental health clusters in PbR); the creation of patient and service user demand for these as commodities e.g. via 'choice' agendas; and the redefinition of the labour force as producers of commodities within new organisational structures (e.g. purchaser/provider split, care management, outsourcing) (Player and Leys, 2008).

The notion of 'strenuous welfarism' developed by Law and Mooney (2007; 2008) effectively describes the dynamics of the restructured welfare labour process in marketised services. It notes the wielding over practitioners of the 'entrepreneurial'

powers of neoliberal managerialism described above by Player and Leys (2008) to increase 'efficiency'. For instance an emphasis on calculable quantification and the transformation of practitioners' tacit knowledge into codified forms enables performance measurement and managerial control in quasi-markets. This results in intensified work regimes in which breathing space and porous time is lost. Practitioners are increasingly engaged in bureaucratic resource management processes and subject to multiple forms of audit (Glasby, 2011) and this reduces time for care and support of service users.

The impact of these neoliberal reconfigurations on mental health practitioners was noted in Chapter 3. These include privatisation and outsourcing of community support services, the transformation of statutory mental health services into corporate entities such as NHS Foundation Trusts and the reduction of discretion through the standardised procedures of care/case management under CPA . This is likely to be intensified through the defined care pathways of Payment by Results (PbR) clusters, and the continued proliferation of performance indicators such as Commissioning for Quality and Innovation (CQUIN) and local authority targets that reshape the mental health labour process.

However there remains an inherent tension between this bureaucratisation and deskilling and the performative discretion and task autonomy associated with professionalism. Therefore, while these processes constrain technical discretion (Harris, 1998; 2003), spaces for its articulation in participative, user-oriented and democratic ways of working still remain. Moreover these tensions between

managerial and professional processes generate resistance that may take the form of 'quiet challenges' in everyday practice (Harris and White, 2009) or more collective forms of resistance through trade union channels (Fairbrother and Poynter, 2001).

Having developed an analysis of the marketisation of services and the welfare labour process, I will now turn to the second dimension of the neoliberal stratum: the emergence of service user involvement and consumerism as significant features of mental health services.

4.5.3.4.2 Service user involvement and consumerism

The development of the disabled people's and mental health service user/survivor movements since the 1970s, described in Chapter 3, has contributed significantly to the way in which the role and rights of the service user are conceptualised within contemporary mental health policy. However it was also argued that this is a complex and contradictory process. This section will provide a framework for understanding the nature of these ambiguities and locate them in the neoliberal policy context.

Some of the key concepts articulated in contemporary welfare discourses such as empowerment and choice have their origin in demands made through mobilisations of service users and broader social movements. However, as section 3.3.2 noted, their later articulation in the policy setting has been shaped by the tension between the context in which these movements and their demands emerged and the contemporary neoliberal policy setting in which these claims are being translated into

policy. Since the 1980s New Right ideology has sought to construct service users and carers as individual consumers of public services. However the democratic language evoked in the presentation of policy tends to obscure the neoliberal individualist orientation that underpins it (Lavalette and Ferguson, 2007). For instance, reforms to extend service user involvement in service provision and development have tended to function more as institutional 'technologies of legitimisation' than genuinely participative and democratic spaces (Carr, 2007). Moreover the extension of user choice heralded in an agenda such as personalisation is embedded in consumerist ideology. These reforms may therefore be better understood as a transfer of responsibility for welfare from the state to the individual that undermines the goal of equity evoked in more universalist models of provision.

These processes of individualisation and risk transfer in the welfare field were described in section 3.3.3 using the term 'responsibilisation'. This implies a reconstruction of the service user as a 'responsible' and 'active' consumer, who carefully manages the self in order to reduce the burden on welfare states. However the tendency of this individualising reconfiguration to marginalise understandings of the role of social factors in the aetiology of experiences such as mental distress and deflect demands on government in relation to the welfare of its citizens suggest that it is the state and service providers rather than the service user that is 'empowered' by such arrangements. Nonetheless the continuing presence of active service user movements both informing practice orientations (for instance the Hearing Voices Network) and organising collectively to challenge policy frameworks (Beresford,

2012) highlights the contested nature of neoliberal reforms and the potential for resistance.

Discussion will now proceed to the third dimension of the neoliberal stratum: the recent emergence of particular forms of risk discourse and coercive management as significant organising principles for mental health services.

4.5.3.4.3 Risk and coercion

It was noted in section 3.4.2 above that stereotypes of madness as dangerous have existed since antiquity. Moreover such conceptualisations of madness have legitimised various forms of suppression and containment of those deemed to be mad from the eighteenth century onwards¹⁸ (Pilgrim and McCranie, 2013). However particular notions of risk, and strategies for responding to it, have shifted over time in response to the move from asylum to community as the primary site for the management of mental distress (Ryan, 1996). In the context of the recent and growing emphasis on risk regulation in society, new and broader organising concepts have filtered into UK community mental health services in the form of prominent risk discourses and management practices (Rose, 1998a). The relationship between these developments and neoliberal welfare policy, already outlined in Chapter 3, will be elaborated in this section.

¹⁸ For instance the custodialism of Victorian legislation such as the 1890 Lunacy Act (Rogers and Pilgrim, 2001)

There was a considerable escalation of debate in the political and public spheres around the perceived link between forms of mental distress and violence during the 1990s in the wake of de-institutionalisation policies and the closure of the Victorian asylums. The homicides committed by Christopher Clunis and others were a particular focus for this, as section 3.4.3 noted. As a result there was an increased orientation to paternalistic risk management and coercive forms of intervention that culminated in an extension of compulsory treatment through the implementation of community treatment orders (CTOs) and extended forensic provision. Section 3.4.4 went on to describe the forms of defensive practice that have transpired and which involve the application of the mechanisms for audit established by neoliberal managerialism. These include the proliferation of tick-box pro-formas and an increased emphasis on medication compliance to manage risk. Moreover as Keynesian welfarist notions of universal provision are eclipsed by the transition to neoliberal welfare, risk increasingly serves as the dominant mechanism for the assessment and allocation of scarce resources.

These developments are closely related to the processes of responsibilisation described in the previous section. There it was argued that the role of the individualised 'responsible' consumer of mental health services is to comply with the medications and interventions prescribed and use services sparingly in the context of welfare retrenchment. However a neoliberal social policy orientation towards individual responsibility rather than social and structural explanations of behaviour provides ideological warrant for increasingly penal and authoritarian responses towards those deemed to have fallen short of such expectations.

I will now summarise the argument presented in this section. The emergence of a new neoliberal stratum during the period since the early 1990s has reshaped organisational and occupational processes within the mental health field. This new stratum has three dimensions: *marketisation of services*; *risk and coercion* and *service user involvement and consumerism*. As the discussion above illustrates these interact in complex ways to provide a structural context that enables and constrains the activities and knowledge of practitioners. However, as this also implies, the neoliberal conjunctural welfare settlement is not uniform but constituted by countervailing as well as dominant ideas and practices. These are associated with forms of resistance. The description of this stratum has noted the constraints placed on practitioners and service users by neoliberalism in the form of managerialist labour processes, responsibilisation and defensive risk management. I have also noted the potential of 'quiet challenges' as well as more active forms of collective resistance, and the democratising possibilities of the individual and collective struggles of service users and their allies.

To conclude, this outline of the adapted strata has provided the layers of Rhodes' pentimento with a firmer ontological grounding. This has been achieved by developing an account of the strata as four conjunctural settlements in the historical development of the English welfare system and the attendant dominant forms of mental health provision within these. It has been argued that the parameters of these shifts in welfare and mental health regime were determined by conditions of political

possibility linked to forms of collective social and ideological struggle and contestation.

4.6 Summary

This chapter has sought to apply a CR epistemological approach to knowledge within the mental health field. The chapter has developed a critique of static, reified conceptualisations of knowledge in general and of models of mental distress in particular. It has been argued that a more dynamic conception of knowledge, incorporating contextually situated and applied knowledge as well as formal propositional (theoretical) knowledge, is required in a complex open system such as the mental health team. Such open systems are constituted by a multiplicity of disciplines, professional groups, practices and knowledge bases indicating the need for an interdisciplinary focus. This has been achieved by utilising the notion of the laminated system. Drawing on this framework, a reconfiguration of Rhodes' (1993) 'pentimento' has been attempted in order to provide a firmer epistemological underpinning for this particular conceptual framework. It has been argued that this adapted model incorporating both diachronic (spatio-temporal) and synchronic (including micro-macro scale) analytical considerations offers the necessary flexibility and reach in developing trans-disciplinary understandings of the mental health field.

The reconstructed pentimento articulates four key historical 'moments' shaping knowledge and practice in mental health services in England: the custodial system of the asylum, the biomedical treatment system of the hospital, community care within

the Keynesian welfare state, and the neoliberal reconfiguration of services. These changes are linked to struggles of collective social agents producing new conjunctural welfare settlements within which novel forms of institution and practice emerge but do not fully displace existing welfare practices and ideology (see Appendix 3 for a diagram of the pentimento).

However, it is important to note that this adapted pentimento framework was developed through an iterative engagement between both extant theory and analytic concepts emergent from data collected during the study. The thesis will now move on to Chapter 5 where this 'adaptive theory' strategy will be outlined alongside a broader account of the methods utilised and data analysis procedures followed during the research process.

5. METHODOLOGY

5.0 Introduction

This chapter will discuss the methodological stance adopted in the study. In the first section a brief overview of the ethnographic tradition within mental health settings and then an outline of the study's combination of ethnographic method with critical realist epistemology will be given. The second section will describe the primary modes of data collection. It will begin with participant observation, including a discussion of field roles and identity, before moving on to semi-structured interviews. In the third part of the chapter an overview of data analysis will be provided. This will set out the procedures followed in the analytic work and explicate the adaptive theory approach and its application in the development of the orienting conceptual framework of the pentimento. Finally, in the fourth section, ethical and political considerations for the study will be outlined.

5.1 Ethnographic methodology

The aim of the study, as noted above, has been to develop a more contextually situated understanding of the impact of restructuring of the mental health field on the articulation and negotiation of frameworks for understanding and responding to mental distress. In order to address this topic an ethnographic methodology was chosen. This method is particularly appropriate for capturing the situated nature of

such frameworks as it enables the researcher to witness human events and engage with participants' rationalisations of these in their lived context, and is thus well suited to the development of an understanding of the social worlds of service users and practitioners in health and social care environments (Savage, 2000a).

It is thus unsurprising that this methodology has been extensively utilised in medical and mental health settings. Indeed a number of ethnographic texts are regarded as classics in the field of social research. An obvious example is *Asylums* (Goffman, 1961), although others include *Timetables* (Roth, 1963) and *Boys in White* (Becker et al., 1961). These texts are situated within the symbolic interactionist tradition of medical ethnography associated with Chicago in the post-war period. This approach eschewed structural understandings in favour of a notion of medical settings as sites of interactional negotiation (Atkinson et al., 2002). However, later ethnographic work in the field of mental health has presented an epistemological challenge to this canon. In their studies of mental health day services (Estroff, 1981), an emergency psychiatric unit (Rhodes, 1991) and a hospital psychiatric team (Barrett, 1996), ethnographic researchers drew on social constructionist and Foucauldian theory to articulate the effects of power in these settings. Nonetheless, like their symbolic interactionist forebears, these studies adopt an epistemological stance that can be characterised as interpretivist/hermeneutic, or are situated within the closely related social constructivist paradigm.

These seminal research studies have undoubtedly made a significant contribution to our understanding of these fields. However while interpretivist and constructivist

epistemologies are necessary they are not adequate for developing explanations of social phenomena because insufficient attention is drawn to the social and material context of semiosis, or the production of meaning (Fairclough et al., 2004). Similarly, an under-theorisation of structure may produce lacunae in relation to power dynamics in interpretivist research (Callinicos, 2006). Cognisant of these issues, some contemporary North American ethnographers of health services are identifying with a more structural-materialist epistemological position, for instance Townsend (1998) draws on institutional ethnography in her study of empowerment in mental health services. However the limitations of interpretivist and constructivist epistemologies are also addressed by the adoption of a critical realist (CR) position. This emerging methodology has been successfully utilised by Floersch (2002) in his study of the strengths case management approach in the U.S. and has underpinned Porter's (1995) widely cited study of racism in nurse-doctor relations in a U.K. hospital. The present study too seeks to align itself with the latter approach, termed reflexive ethnography by Davies (2008) that integrates ethnographic methods with the epistemology of critical realism.

There is always a hermeneutic moment in social research as social phenomena are intrinsically meaningful (Sayer, 2000). Social science is therefore necessarily concerned with actors' meanings or the *conceptual*. However a CR approach moves beyond the ideographic illumination of individuals' understandings and actions associated with interpretivism. While the importance of an exploration of actor's phenomenological reality is retained and encouraged in CR approaches, their interpretations are not taken to wholly constitute that structure (Davies, 2008).

Instead in a CR approach, explanation within this stratified ontological domain involves movement from the level of the concepts, happenings and events requiring explanation to the mechanisms and structures generating them. According to this conception, then, ethnography has a twofold role Porter (2002, p.65):

First, it is used as a method to uncover the manifest interactions of the social world, which are then subjected to the transcendental processes of theory generation to infer the structural conditioning of those interactions. Second, it is used to subsequently test the veracity of theories concerning the nature and effects of the structures pertaining.

The methodological implications of this proposal will now be considered in greater detail. Firstly, the multi-layered (or laminated) nature of the social context requires the researcher to develop a clear picture of individual interactions at both the level of action and of motivation. The utility of the close observational techniques of ethnography is manifest here. The second is that theoretical work is required to explain the patterns of individual interaction observed using this ethnographic approach. In this respect, critical realist research maintains ethnographic data collection techniques while rejecting some of the epistemological assumptions typically associated with this method in order to refocus beyond individual experience and towards the elucidation of structured relations.

The strength of CR as an epistemological underlabourer for qualitative and ethnographic methods is that it facilitates thick description of the setting at multiple and interacting ontological levels: those of concepts, action and the structural context of human activity and in doing so warrants forms of non-predictive causal explanation. As Davies (2008, p.22) notes, CR:

[P]rovides a philosophical basis for ethnographic research to provide explanatory... abstractions while also emphasizing its rootedness in the concrete, in what real people on the ground are doing and saying.

The final part of this section will consider the implications of these ontological and epistemological considerations for the research methodology chosen for this study. It will argue that the setting of a multidisciplinary CMHT presented particular ontological challenges but that a critical realist epistemology was well suited to address these and develop theory in relation to this particular research topic.

This study has sought to develop a contextually situated understanding of the conceptions of mental distress articulated within the multidisciplinary environment of the CMHT by members of the various occupational groups (and service users and carers). In this context it is assumed that meanings, actions and interactions are, to some degree, structured by the differing disciplinary knowledge bases associated with the various professions. In this respect theoretical knowledge, e.g. particular social or biomedical models, can be considered generative mechanisms or structures (as reasons are causes). However, as noted above, the articulation of these models has to be situated in the dynamic interaction between concepts, actions and structured relations within open systems. The actions of individuals are *not* determined by structural relations but such structures provide “the means, media, rules and resources available to enable or coerce action, [and] will engender towards certain courses of action” (Porter, 2002, p.66). Thus while the agents in this multidisciplinary team context might be expected to think and act within the matrix of the generative structure of their particular disciplinary knowledge bases (that is, the psychiatrist drawing on the medical model, and the social worker on social theories),

because this structure operates within an open system alongside other structures its effects will emerge as tendencies as opposed to constant conjunctions. The beliefs, intentions and actions of individual practitioners are also simultaneously influenced by a number of other structures which might include, for example, the more generic institutional roles which managerialist reforms of services are ushering in.

Moreover in the CMHTs in which I carried out my research, the variety of professional groups represented and their diverse knowledge bases is unlike, for instance, some recently studied community mental health settings in the U.S. where one dominant approach (such as the strengths case management approach) is explicitly identified, advocated and inculcated within services (Floersch, 2002). Unlike the participants in Floersch's ethnographic study, in the UK practitioners in community mental health are less likely to explicitly identify the models which inform their understanding of mental health difficulties in the course of their everyday work (though this may not be the case for specialised psychology services, for instance). This may be in part because, in such multidisciplinary teams, there tends to be an expectation/assumption that a holistic and inclusive bio-psychosocial model (BPS) is now dominant. Alongside this is the view that earlier disputes and tensions between competing perspectives are increasingly obsolete. However, I would argue that competing models remain a site of contestation and controversy. Therefore, as articulation of these may be seen as divisive, there is a resultant tendency to minimise and suppress the overt expression of such differences.

Meanwhile, and related to this, alongside the rhetoric of BPS as a more integrative knowledge base (i.e. propositional knowledge), the increasingly generic roles and practices of the different professional groups may be producing a greater convergence of practical knowledge within this field. As noted in Chapter 4, professional activity incorporates practical as well as propositional knowledge (Polanyi, 1958 and Ryle 1949) (cited in Bhaskar, 2008b) and this tacit dimension of knowledge and its embedding within a more generic practice may have implications for the explicit identification of frameworks by practitioners in the course of their work.

In this way the ontology of the field has presented particular challenges for the methodology. However CR has offered a means to cope with these because of its rejection of a 'flat' ontology of surface appearances and the notion of ontological depth at its core (that is, that there are real generative mechanisms which underlie events and our human experience of them). For this reason CR can explain why causal tendencies such as particular models of mental distress, or the effects and tensions that arise from their interaction, may remain latent - they are unrealised due to the presence of other countervailing tendencies. Phenomenological/ narrative/ constructivist epistemologies may not facilitate the development of such analyses.

In view of the occurrence of social phenomena in open systems with determination operating at multiple levels within a stratified ontology, explanation requires reference to multiple causal mechanisms. The notion of the laminated system was proposed in the previous chapter as a means to develop an analysis of such relationships. Later in this chapter the utilisation of the pentimento (Rhodes, 1993), one form of spatio-

temporal laminated system, as an 'orienting conceptual framework' for analysis will be discussed in greater detail.

In summary, ethnographic practice informed by CR requires the researcher to develop a picture of individual interactions at both the level of action and of motivation. In this study, the utility of the close observational techniques of ethnography has been perhaps more apparent with regard to the activity of practitioners and users, and further work has been required in order to realise this in relation to their motivations for the reasons outlined above. As a result, further exploration of the realm of motivation has been accomplished via interviews.

However, while CR regards agents' conceptualisations of their activity within the field and of the field itself as crucial and necessary, this approach also recognises that such knowledge may be partial and fallible. While the constructivist paradigm which underpins much contemporary ethnographic research tends to bear more exclusively on the agency and conceptualisations of the actor, CR develops an understanding of the context, including the way in which context places constraints upon and provides enablement for certain types of action by the agent. CR therefore provides a more satisfactory epistemology for applied research than versions of harder constructivism which under-theorise context. In this critical realist approach to research ethnographic data collection techniques are maintained while some of the methodological assumptions associated with them are rejected in order to refocus beyond individual experience and towards the elaboration of structured relations.

5.2 Methods of data collection

The chapter will now turn to discussion of the primary research methods used to collect data for the study: participant observation and in-depth interviews.

5.2.1 Participant observation

The study was of limited scale, focusing on two teams, and thus constituted a particularistic (small group) ethnography. Participant observation formed the primary research method. Ethnography typically involves the immersion of the researcher in a social setting over a lengthy period. In this case, the initial pilot phase of the study involved a relatively short period of fieldwork: eight-weeks from June until August 2008 within the first fieldwork site, Northville CMHT, during which I attended on average three days per week, spending approximately eight-hours per day with the team. However the second phase involved an extended period of fieldwork on three to four days per week from October 2009 to early July 2010. At the midway stage during February and March 2010 I took a short planned break from fieldwork to begin initial analysis. Following completion of the fieldwork in July 2010 I withdrew from the field again to engage in further data analysis, and to develop then pilot the interview schedule. Following this, in-depth interviews and further limited ethnographic data collection were conducted between January and September 2011. The findings of the study are predominantly based on the fieldwork conducted at Southville CMHT. An overview of the data set is presented in Appendix 2.

Data were collected in the CMHT and other related settings. This required immersion in daily routines and functioning in order to observe the practices of the team. The latter included the individual and group casework meetings of practitioners with service users, and multi-professional fora such as Care Programme Approach, ward round, Acute Response Team (ART) and weekly CMHT meetings. A particular focus was modes of formal and informal interaction and information sharing between practitioners. Each day data was recorded in several formats. Scratch notes were hand written contemporaneously while at the end of each day detailed field notes and reflective memos were typed up on a word processor. There were a number of areas of focus for data collection such as professional roles, power, status, conflict, values, labour process, formal and informal information sharing, use of language and argot, communication styles, flexibility, accountability and decision-making.

The selection of the fieldwork setting involved both pragmatic and theoretical considerations. Statutory CMHTs were chosen as an appropriate setting to address the research topic because this type of team has been the mainstay of community mental health provision and a number of occupational groups work together within an integrated team framework. This was also a pragmatic choice as I was employed as a social worker within this particular Trust during the period when access was being negotiated.

Sampling 'within the case' was identified as another important consideration. This took place along three key dimensions: time, context and people (Hammersley and Atkinson, 2007). To address the temporal dimension, I sought to vary the days on

which I attended from week to week in order to incorporate variations in team members' routines, for instance Approved Mental Health Professional (AMHP) duty. A number of contexts were sampled alongside the CMHT office, including service users' homes and professional duties external to the CMHT such as in-patient ward rounds. Whilst achieving a broad sample in terms of the third dimension, *people*, was more challenging during the pilot study at Northville CMHT, as social workers were initially more willing to actively participate in the study than, for example, nurses, this was not the case during the period of fieldwork with the second team, Southville CMHT. The connection between this latter issue and my identities and relationships in the field will be examined in the next section.

5.2.1.1 Field relations

The utilisation of a reflexive ethnographic methodology for this study was noted above. Description of my positioning within the field is thus an essential element. This has two related dimensions: my field role as a participant observer and the broader issue of identity work within ethnographic research.

The first of these, field role, concerns how the ethnographer positions the self in the research setting on a continuum from complete participation to complete observation. The most frequently adopted orientations described by Junker (1960) (cited in Hammersley & Atkinson, 2007, p.85) are participant-as-observer (for instance, adopting an 'insider' perspective by becoming a practitioner within the team being researched) or observer-as-participant (an 'outsider' orientation as observer). My own field role reflected the latter because, though data were collected at a Mental

Health Trust in which I had formerly worked, I was not employed as a social worker in either of the teams in which I conducted the fieldwork. My positioning was thus as an external researcher, though I openly acknowledged my former role as social worker to participants.

In practice, my predominant field role within formal team or casework meetings was as an observer, though I would engage in appropriate non-therapeutic social interaction to place participants at ease, and interact when invited to do so. However in more informal work settings such as the office I would spend time alongside practitioners interacting with them to explore aspects of their work, but also engaging in workplace conversations that might or might not be practice-related. However, whilst at the outset this might be considered an 'outsider' position, over time such insider/outsider distinctions become less clear cut and this has advantages but also creates tensions for data collection and analysis. These can be better understood via an exploration of the second dimension, identity work in the field.

Identity work is often described by ethnographers in terms of impression management, for instance the types of clothing worn and speech used by the researcher to facilitate the development of relationships in the field (Hammersley & Atkinson, 2007). However such a focus tends to underplay the contextual situatedness of researcher and researched. Coffey (1999) notes the self is positioned in a range of contexts including cultural, historical, political and gendered, and these impact on data collection. Three in particular, all of which raised complex dilemmas

for me in the course of the fieldwork, will now be explored in greater detail: personal, professional and political identities.

My identity as a (white) male was a significant factor shaping data collection. I was told by one social worker that several of the female service users with whom she worked would not be comfortable with observation by a male researcher due to their experience of childhood sexual abuse. This is reflected in the study as a whole, where a majority of service user participants were male in spite of my attempts to recruit more female service users (See Appendix 2D). The two case studies in Chapters 6 and 7, both focusing on male service users, also reflect this.

Professional identity also proved salient because, as noted above, I had previously practised as a social worker within the Trust where fieldwork was conducted. This was another dimension that both facilitated and proved an obstacle to access at various points. Whilst this identity proved advantageous in terms of initially accessing the fieldwork sites, 'insider status' can shift to that of outsider in the context of inter-professional tensions. Gordon, a social worker at Northville CMHT considered that social workers would,

[P]robably [be] more willing [to engage with the study than nurses]... With social workers and nurses it is a team within a team. If you were a nurse it might be the other way around.

Certainly data collection with nurses proved more difficult at this pilot stage of the study. Learning from this experience, I subtly shifted my presentation of self during subsequent data collection with Southville CMHT, de-emphasising my social worker

status and referring to myself instead as a 'former practitioner', though always disclosing my professional identity whenever asked.

The complex methodological implications of this professional identity were also apparent when observing casework interactions with practitioners. Whilst my practitioner identity helped me to gain acceptance in the field, this also generated the risk of over-familiarisation and a lack of critical distance, which has been termed 'going native' (Coffey, 1999). I was constructed at times as the 'expert' and invited to contribute my professional opinion in the contexts of meetings and generally responded by politely reminding participants of my 'outsider' researcher role. However, this raised ethical dilemmas for me and, on a couple of occasions, I did share information with participants about services or resources that I considered may be of benefit to the service user.

Another related issue was professional credibility. For instance, it was sometimes difficult to elicit the rationale for forms of intervention from practitioner participants because they assumed the reasons would be 'obvious' to me as an insider (i.e. a former practitioner). As Savage (2000b) notes, things that practitioners know 'too well' may not be verbalised by them in daily activities and this is one of the challenges for the ethnographer. Moreover when analysing field data I noted that on occasion I had not probed practitioners for explanations and reflected that this was perhaps because of my own assumptions rooted in practice experience. To this can be added the reflection that I sometimes found it difficult to adopt the required 'not knowing' stance, what Vail (2001) describes as 'the performance of incompetence', to elicit informants'

explanations of their actions. This reinforced to me the importance of retaining an outsider perspective or, as Walsh (2004) has put it, maintaining a view of the setting as 'anthropologically strange'. I sought to address this threat to validity in data collection and analysis by arranging periods of withdrawal from the field. During these I immersed myself in the literature, engaged in data analytic work and explored my fieldwork practice and emergent theoretical ideas within the setting of research supervision in order to reinforce a critical distance from the field.

A final implication of professional identity relates to the unequal power dynamic between users and practitioners within mental health services (Beresford and Wallcraft, 1997). This has a significant impact upon data collected by researchers identified as practitioners. For example, service users and carers may be reluctant to criticise a service to those they perceive as providers if they fear this might lead to losing it (Faulkner and Nicholls, 2001). Indeed, Rose (2001) notes that service user participants are frequently more open and responsive in studies where the researcher shares a service user identity. As a result it should be acknowledged both that my perceived professional identity¹⁹ has consequences for the validity of data collected from service users and carers, and that the frameworks for understanding developed in the study tend to be more reliant on data collected from practitioners than people with lived experience of mental distress.

The issue of political, as well as personal identity was also significant in building trusting relationships in the field. As I got to know team members, on occasions we

¹⁹ In my interpersonal interactions with and in the information sheet for service users and carers I emphasized my identity as a 'former' practitioner who was not currently employed or reporting to the NHS Trust.

discussed politics and I communicated my involvement in activist campaigns. Later, on attending a leaving drink at the pub for Bob, a community mental health nurse (CMHN) at Southville CMHT who was about to take a two-month sabbatical break, we also discussed my membership of a music collective. He told me that he was pleased that my research with the team was working out, and explained: “when the team found out about your politics that made a big difference, then when they found out about the music and djing that sealed the deal” (Fieldnotes 22.10.09). This highlights the centrality of meaningful social relationships, friendships and emotional connections in the field, and the necessity of self-disclosure. Nonetheless fieldwork is, as Coffey (1999) notes, *work* and is as such different from purely private relationships and thus the researcher must negotiate public and private relations of meaning. These raised ethical dilemmas for me about the extent of informed consent when participants’ disclosed information in informal settings such as the pub. This is a reminder that ethnographic research is intimate and interpersonal craft-work involving one’s sense of personhood and within which relationships develop that can be fulfilling, but also fragile and exploitative.

My political identity was also a relevant issue because of the highly contested nature of the mental health service context. Ethnography operates across the boundaries of the powerful and powerless, sensitive to inequalities both between service users and practitioners, and front line workers and senior managers. As Roger (CMHN and Unison trade union representative) became aware of my political perspective, he began to share and disclose information in the hope that the study would constitute a challenge to these relations of power within the organisation (see Chapter 8). Thus

my political orientation had a particular impact on the kind of data I was able to collect. However, whilst I shared Roger's broader political aspirations, I was also concerned that his perception might overestimate the potential political impact of the study. Nonetheless, my orientation is one that views research not as neutral but a profoundly political exercise involving particular competing sets of agendas and interests (Humphries, 2008). I hope that by reflexively acknowledging this political positioning and utilising the data revealed to me because of it to engage in a research practice that views social spaces 'from below' - from the vantage point of the less powerful – the study offers the potential both to 'speak with' research participants such as Roger and to understand and analyse social formations of inequality (Armbruster 2008). This perspective will be discussed in greater detail below in the ethics and politics of fieldwork section.

Having examined field roles and identity in the context of a discussion of an ethnographic approach, the discussion will now turn to the other primary method utilised: in-depth interviews. This section will discuss practical and epistemological considerations for this stage of data collection.

5.2.2 In-depth interviews

The pilot study established the utility of an ethnographic approach for addressing the research questions, but also indicated a need for inclusion of supplementary methods to further strengthen the methodology. Therefore, following the completion of a subsequent period of participant observation, further data collection involving the

additional method of in-depth interviews with practitioners, service users and carers was carried out. In total interviews were conducted with 21 members of staff, mostly between February and September 2011. The occupational identity of the interviewees was as follows: 6 social workers (including 1 student), 7 community mental health nurses, 3 psychiatrists, one occupational therapist, one clinical psychologist, one welfare rights worker and 2 administrative staff. In addition 8 service users and 3 carers were interviewed (see Appendix 2G). All interviews were digitally audio-recorded with relevant sections then transcribed.

5.2.3 Documentary data

One further additional source of evidence was documentary data produced within the CMHT and Mental Health Trust setting. As Coffey and Atkinson (2004) observe, the social worlds of participants can be understood by the researcher not only through face-to-face interaction but also via the examination of documentary constructions of reality. I found examination of electronic case records to be particularly useful as a way of exploring some of the ways in which practitioners understandings of mental distress were constructed and types of intervention recommended within a formalised and official context. This also drew attention to the division of professional labour (Prior, 1993) and some of the convergences and divergences between formal accounts and practices in the field.

With the specific consent of the service users concerned and of the Trust, and where this data was available, I accessed information such as progress notes, care plans,

assessments including risk, care programme approach (CPA) forms, hospital admission summaries, approved mental health professional reports and letters. This data was only collected in relation to eight service users, predominantly those interviewed (see Appendix 2H).

Several other informal documentary materials were also gathered, for instance an anonymous article discussing and critiquing managerialism in mental health services that was circulated informally by Southville team members, and a satirical newsletter produced by practitioners in the Trust that criticised senior management and service reconfigurations. These had been forwarded to me and helped to illuminate power relations and resistance within the field. I was also forwarded a report produced by the Southville CMHT manager providing an overview of the service (see Appendix 2H).

The chapter will now turn to description of the procedures utilised to analyse the data.

5.3 Data analysis

The process of data analysis was not clearly delineated from other stages of the research process and remained a continuous focus throughout the fieldwork and into the final stages of the project. Moreover the development of the analytical framework for the thesis was an iterative one. This involved a creative tension between my experiences in relation to participants as recorded in the field notes and their remodelling into the form of theoretical generalisations articulating the strata of the

pentimento. This approach involved engaging in a critically reflexive process to orient analysis and theory development. In order to justify this, the first section will clarify the role of theory and concepts in analysis via an overview of the critical realist notions of adaptive theory and orienting concepts (Layder, 1998). The following section will begin by providing an account of the stages involved in the process of coding data. It will elucidate the iterative movement between data, theoretical reflections and extant theory that contributed to the development of the orienting conceptual framework of the pentimento. The final sections will provide the rationale for the presentation of the findings in the form of two detailed case studies and note issues arising from the analysis that impacted on its quality.

5.3.1 Adaptive theory and orienting concepts

The study has adopted an analytic strategy that utilises the work of Layder and his notions of adaptive theory and 'orienting concepts' (Layder, 1993; Layder, 1998). This approach offers an integrative framework incorporating elements from, but seeking to transcend the limitations of deductivism and inductivism. It seeks to construct novel theory in the process of ongoing research practice by drawing from aspects of prior theory, general or substantive, in conjunction with theory emerging from data collection and analysis (Layder, 1998, p.27). The relationship between prior theory, which can include models, concepts and conceptual clusterings, and emergent theory is understood as a process of dynamic interchange. Furthermore, this approach seeks to formulate links between the level of actors' meaning making and that of the institutional and wider systemic context.

Prior theory or orienting concepts are proposed as a crucial element in this approach to theory development. In order to meet the requirements of an integrative framework however, orienting concepts must fulfil two key criteria: they should refer to both *objective and subjective* elements of the social world; and should focus on *social processes*, that is, incorporate spatial and temporal dimensions (Layder, 1998, p.101). A particular benefit of utilising orienting concepts is that they provide a *provisional* means of ordering large quantities of data in the process of analysis though this initial orienting conceptual frame may be supplanted or modified later.

While orienting concepts are similar to Blumer's notion of sensitizing concepts (Blumer, 1954) (cited in Layder, 1998, p.109), they were developed within differing meta-theoretical frameworks: sensitizing concepts within the interpretivist paradigm, orienting concepts within the critical realist (Layder, 1998, p.109). Both denote flexibility but sensitizing concepts have a more limited application specifically in relation to actor's interpretive frameworks, whereas orienting concepts can be applied to analysis of social relations and structure as well as meanings. This approach recommends elaborating from core orienting concepts to develop a basic conceptual framework at an early stage in data gathering and analysis but Layder (1998) warns against forcing the data into pre-conceived categories and argues that this strategy needs to be utilised with caution.

Overall then, while the process of theory development outlined by Layder (1998, p.27) is described as emergent, this is in a different sense from that associated with

grounded theorising. In the adaptive framework it is legitimate to utilise prior conceptual frameworks (orienting concepts) as well as data generated during research and for both to contribute to the development and elaboration of new theory.

The specific procedures followed to allow identification of orienting concepts and the development of adaptive theory for the study involved an initial stage of provisional coding of data, and subsequent development of core and satellite codes. These processes will now be described in greater detail.

5.3.2 Provisional coding: initial organisation and analysis of data

The first period of fieldwork with Southville CMHT commenced in October 2009 continuing through until July 2010. At this stage I collected data in the form of ethnographic field notes and reflective memos. The latter incorporated reflections on my data and experiences in the field and their relationship to existing theory and the study's research questions. However, as Hammersley and Atkinson (2007) note, ethnographic fieldwork is demanding and time-consuming and this meant that substantial formal analysis was not possible at this point. I therefore took a short break from the field during February - March 2010 to enable an initial overview of the data and begin analysis.

At this preliminary stage provisional codes were assigned to sections of the data (Layder, 1998). This is more flexible and open-ended than the highly prescriptive approach to open then axial coding promoted in grounded theorizing. As will be

discussed below, while some codes were *in-vivo* and emerged from categories produced *ex nihilo* from data from the field (e.g. 'corridor psychiatry'), others like 'integration' and 'encompassment' drew instead on pre-existing theoretical materials (Barrett, 1996) reflecting an iterative movement between data and extant conceptual frameworks in this early stage of analytic work.

At this juncture the provisional codes identified related to three areas. The first set of codes described policy and practice aspects of managerialist reform: *performance targets; acute response team (ART); RiO database; personalization; marketization* and *HoNOS PbR (payment by results)*. Second were codes that illustrated certain forms of orientation in practice that align with, manage or challenge local policy prescription: *discretion; competition; conflict; strategic action* and *resistance*. The third related to dimensions of extant analytical frameworks that seemed relevant as data analysis developed. These included codes drawn from Rhodes' (1991; 1993) theorization of the historical development of psychiatric institutional practice: *confinement; biomedical gaze* and *systemic/community approaches*, and from Sennett (2006) on the dynamics of the workplace under contemporary capitalism: *village to rail; experience to flexibility* and *short-termism*. Codes based on analytic categories described in a study of inter-professional practice in mental health (Barrett, 1996): *integration; encompassment* and *exclusion* were also utilised.

As this exposition suggests, data analysis oriented to multiple impacts of the market and managerialism on the field. However the data at this stage did not enable detailed exploration of the ways in which practitioners and service users

conceptualise mental distress. This was a result, in part, of a reduction in contact time with service users described by practitioners due to an increase in administrative pressures that curtailed opportunities to observe direct practice. It was also because the conceptual frameworks utilised for understanding distress were not often explicitly articulated during practitioners' everyday case meeting encounters with service users. These conceptualisations did however seem to emerge more frequently during periods when service users experienced various forms of mental health crisis. It was at such points that the perceived reasons for these events and suggested forms of response and intervention were discussed and debated in multi-disciplinary fora such as team meetings and ward rounds. For this reason my focus shifted towards arranging to attend and audio-record such meetings during the April - June 2010 period (see Appendix 2E) whilst continuing with the collection of other forms of data.

Having re-oriented data collection in this way and then completed further fieldwork I withdrew from the field again in July 2010. This enabled another phase of data analysis. Working through the more recent Southville data it was necessary to extend the number of codes. These related to a further two areas. The first reflected the *emic* dimension, that is in-vivo or local categories that practitioners themselves utilised to describe their activities (Given, 2008): *sleep, mood and meds; corridor psychiatry; local knowledge* and *chronic*. The second encompassed a broad variety of codes, from dimensions of professional role performance: *risk management; therapeutic intervention; consumerism and choice; service user involvement* and *outcomes* to inter-personal or value orientations in practice: *humour; egalitarianism;*

coping strategies and *practitioner-manager tensions*. These provisional codes are set out in Table 1.

Table 1. Provisional Codes

| |
|--------------------------------|
| Performance targets |
| Acute response team (ART) |
| RiO database |
| Personalisation |
| Marketisation |
| HoNOS PbR (payment by results) |
| Competition |
| Discretion |
| Strategic action |
| Resistance |
| Confinement |
| Biomedical gaze |
| Systemic/community approaches |
| Village to rail |
| Experience to flexibility |
| Short-termism |
| Integration |
| Encompassment |
| Exclusion |
| Sleep, mood and meds |
| Corridor psychiatry |
| Local knowledge |
| Chronic |
| Risk management |
| Therapeutic intervention |
| Service user involvement |

| |
|-------------------------------|
| Egalitarianism |
| Consumerism and choice |
| Outcomes |
| Practitioner-manager tensions |
| Humour |
| Conflict |
| Coping strategies |

I will now present two data extracts from my field notes to illustrate the practical elements of this coding process. The first relates to the Acute Response Team (ART) pilot then being conducted at Southville CMHT. ART is a model for organising the management of referrals to the CMHT, which involved two team members on a full-time basis, occupational therapist Kerry and community mental health nurse (CMHN) Roger. The CMHT Consultant psychiatrist, ST5 psychiatrist and deputy manager also ring-fenced part of their week to provide input to this service. The main function of ART was to take referrals, carry out initial assessments and refer on those assessed to an appropriate service. This replaced a system of rotating 'intake' duties amongst CMHT members. My field notes record CMHN Bob explaining this new system to a colleague from another team:

ART is a development precipitated by the fact that "GPs now buy in services, and [ART] keeps them sweet by faster response times [to referrals], even though they're not unhappy, but have been brought in elsewhere like by the Tavistock Clinic. Then they go on the waiting list if needs be" [...]

Shortly after [another nurse] asks Bob what time the team meeting is starting (as it's late). Bob replies that they are just waiting for the ART meeting to finish downstairs. He commented, in a bleakly humorous manner: "they're probably beating the shit out of each other down there... [turning to me] you didn't hear that Richard." (Fieldnotes 21.10.09)

Several codes were assigned to this section. The overall segment was coded *Acute response team (ART)*. Within this the first paragraph the 'buying in' (contracting out) of services was coded *marketization* but also *competition* to reflect practitioners' re-oriented relationships to other services - as purchasers or providers - within daily practice. During a subsequent phase of coding *consumerism and choice* was also added here. The second paragraph was initially coded *conflict*. The additional codes *practitioner-manager tensions* to reflect the particular power dynamics and *humour* to describe Bob's orientation in this situation were added during the next stage of coding.

The second extract highlights other aspects of policy reform in statutory services: the personalisation agenda, individual budgets and direct payments.

Farooq [social worker] explained to me his concerns about the personalisation agenda. He gave the example of a service user for whom he had managed to secure direct payments (DP) - the first client on the team to use this system. He recounted that this service user had applied for funding for a college course through the usual panel funding mechanism. This had been turned down. He said that Terry [Assistant Borough Director] then suggested that if the application was made via DP then this might be accepted. He applied in this way, it was accepted, and DPs were put in place.

However, Farooq remained concerned that [under this new system] "targets will come first, rather than needs". He worried there was a lack of fairness, arguing that the plan to close day centres would have negative implications for some clients. He said that some would be able to manage this new system of individual budgets (IBs) but others would not and would lose out as a result. (Fieldnotes 27.10.09)

This whole segment of data was given the code *personalisation*. However the first paragraph was also coded *strategic action* to reflect the re-orientation required of Farooq in order to secure funding for this service user, and *performance targets* in the passage where Farooq reflects on the perceived tension between service user

need and performance indicators. Additional codes were later assigned. These were *egalitarianism* in the first part of paragraph two, where Farooq considers the distributive impacts of individualisation of services. The codes *consumerism and choice* and *service user involvement* were also added in the second part of this paragraph to reflect the shift towards individual responsibility under the IB system.

5.3.3 Reflective memos

The move from provisional to core coding required the use of the next element in the analytical process: reflective memos, or theoretical memos to use Layder's (1998) terminology. My reflective memos took the form of a log that I kept alongside my daily field notes. Here I reflected on the ways in which my data and codes connected to, exemplified or contradicted the emergent and extant concepts and categories. This process enabled me to hold in creative tension five important dimensions that emerged during the earlier stages of fieldwork. The first was my observation of participants and their extensive testimony describing the effects of practice reconfigurations to align with new performance indicators and bureaucratic requirements. The second was the commodification of welfare work explicated via a range of sociological and labour process models. The third was the conceptualization of mental distress in multiple and contested ways described in the anthropological and sociological literature. The fourth were some apparent oscillations and tensions between orientations for understanding and responding to mental health needs that unfolded in the interactions I encountered in the field. The fifth was the implication of explicit and tacit forms of knowledge for my data collection. These five aspects sat

uneasily alongside each other, each jostling for primacy, seemingly irreconcilable with the others. And yet I felt each to be of great significance in developing the kind of understanding of the field necessary to address my research questions. These five areas and their inter-relationships will now be discussed.

The first area addressed in my reflective memos concerned the effects of new public management and managerialism. The intense impact of these on practitioners is reflected in the initial set of five provisional themes (*performance targets* to *HoNOS PbR*) noted above. Their effects were highly visible as the team experienced the transition to new forms of information and communications technology (ICT) and bureaucratic data management that reconfigured the nature of practitioners' daily practices in significant ways, a process that was overwhelmingly perceived in negative terms by team members. The challenge, however, was that while the data vividly illustrated these vicissitudes my immersion in the setting at this transitional moment for practitioners meant that the opportunity to observe practitioner-service user interaction and thus models-in-use was constrained by one of the effects of these reforms: reduced contact with service users. As Bob (CMHN) explained to me shortly after the discussion of ART elaborated above in section 5.3.2: "[you are] probably around at the worst time in terms of getting support [for the study] from the team because of these ongoing issues [around RiO/ART]" (Fieldnotes 21.10.09).

Nonetheless my engagement with the second of these dimensions, the critical literatures examining the sociology of work and restructuring of the welfare labour process in line with market imperatives, provided important influences on the

development of the analysis. This was achieved through utilizing several theoretical lenses to approach the data. These include, as noted above and in Chapters 3 and 4, Law and Mooney's (2007; 2008) conception of strenuous welfarism, Player and Ley's (2008) model for the commodification of health services and Sennett's (2006) theorization of the culture of the new capitalism. At this stage, following an abductive approach, the data were recontextualised with the aid of each of these multiple theoretical frameworks to assess their analytic purchase (Danermark et al., 2002). These offered useful insights into the transitional nature of the contemporary institutional context of practice, underpinned by a broader conception of generative processes at the political-economic level and, as such, point to the importance of an historical dimension to theory-building (Layder, 1998).

However, there remained a question mark regarding the relationship of these processes to conceptualizations of mental distress. Another theoretical framework of which I was cognizant at this stage of data analysis was the Models project noted in Chapter 4 (Fulford and Colombo, 2004). However, as I will examine in this section, the notion of practitioner knowledge there did not seem to capture some of the apparent shifts in conceptualization in practice that my data indicated. My reflective memos considered this in relation to dimensions of biomedical and social paradigms. For instance, CMHN Phil identified an interest in the work of radical psychologist and critic of biomedical approaches Rufus May, and identification with the psychosocial clubhouse approach. However I observed a casework interaction with a service user called Ron shortly after, where Phil and ST5 psychiatrist Edwina foregrounded the adjustment of his medication dose. After the meeting Phil expressed the view that:

“new medication may be the key [to stability for Ron]” (Fieldnotes 19.11.09). This reinforced his earlier comment that “you just need to get the medication right and the rest will follow.” Another example was when CMHN Roger expressed qualified support for diagnostic categories, lauding a colleague with whom he had worked because he “wasn’t afraid to diagnose people...” (Fieldnotes 27.11.09). However, on another occasion he used the phrase “diagnosis human being” to critique bio-medical reductionism in psychiatric practice.

Similarly, while social workers might be expected to orient to social approaches and did express concern about medical dominance in teams, many regularly utilized biomedical diagnostic categories and terminology to describe the mental health experiences of service users. For instance when I mentioned to social worker Michael that I was meeting a service user who had agreed to participate in my study, he immediately asked her diagnosis. On another occasion Farooq expressed to me his concern about a diagnosis of catatonic schizophrenia attributed to one of his allocated service users. I initially wondered whether he rejected diagnostic labelling, but he clarified that he agreed with the schizophrenia formulation but not the catatonic element. Meanwhile Ruth expressed concern about losing her social work identity, but frequently used the medicalised term ‘patient’ rather than service users. I considered these oscillations and tensions to be interesting and significant and I sought to examine them in greater detail.

They seem to represent what Longhofer et al. (2013) call ‘phenomenological practice gaps’ between official accounts or formal models of practice and what actually

happens in everyday contexts. In reflective memos I explored the necessity of considering the tacit and its relationship to the explicit dimensions of practice. Whilst the Models project spoke to the more explicit theoretical orientations in practice, and my context-rich ethnographic data produced a window onto the contextually situated and tacit dimensions of knowledge, I struggled with a way of synthesizing them in my analytical work. The approach utilised to move forward from this impasse is described in the next section.

5.3.4 Core coding: development of the orienting conceptual framework

At this stage, and alongside reflection and discussion within supervision, I followed Layder's (1998) suggested strategy for providing direction in the analytical work by searching for key themes, or *core codes*, that give shape to the data. Core codes can be either emergent from the data or derived from theoretical resources in the literature. Layder suggests using theoretical memos to reflect on linkages between codes, concepts and data, and in this way develop orienting conceptual frameworks to manage and order the large amount of data collected.

Following this advice, I re-examined the data using Rhodes' (1993) *pentimento* as an orienting conceptual framework. The *pentimento* seemed apposite because it appeared to offer the potential to integrate the five key dimensions noted in section 5.3.3 above: organizational reconfigurations, the commodification of welfare work, conceptualizations of mental distress, oscillations and tensions between these orientations and both explicit and tacit forms of knowledge. Moreover it met Layder's

(1998) criteria for orienting concepts by elaborating both the relationship between objective and subjective perspectives, and between the spatio-temporal context of mental health practice and knowledge.

The first core codes identified were therefore related to the strata of the pentimento: *confinement*, *biomedical gaze* and *systemic/community approaches*, and these are illustrated in Table 2. A number of the provisional codes identified earlier were then reordered as *satellite codes* or subsidiary themes within these broader core thematic categories.

Table 2. Core Codes: Pentimento

| CONFINEMENT | BIOMEDICAL GAZE | SYSTEMIC/ COMMUNITY |
|--------------------|----------------------------|--------------------------------|
| Confinement* | Biomedical gaze* | Systemic/community approaches* |
| | Sleep, mood and meds** | Integration |
| | | Encompassment |
| | | Exclusion |
| | | Therapeutic intervention |

*Theme extended from provisional code

**Satellite code positioned within more than one core code

A second cluster of core codes, *strategic action* and *resistance* were then identified that related to contextually situated forms of activity and parallel the notion of ‘gesture’ in Rhodes (1993). The satellite codes within these core categories are set out below in Table 3.

Table 3. Core Codes: Situated activities

| STRATEGIC ACTION | RESISTANCE |
|-------------------------|-------------------------------|
| Strategic action* | Resistance* |
| Competition | Practitioner-manager tensions |
| Discretion | Humour** |
| Humour** | Service user involvement** |
| Conflict | |
| Coping strategies | |

*Theme extended from provisional code

**Satellite code positioned within more than one core code

However, a number of provisional codes did not seem to fit within this model. For this reason a third cluster of core codes related to the contextual features of contemporary practice: *market*, *managerialism* and *risk management* represented in Table 4 below was developed.

Table 4. Core Codes: Context of contemporary practice

| MARKET | MANAGERIALISM | RISK MANAGEMENT |
|---------------------------|---------------------------|------------------------|
| Marketisation* | Performance targets | Risk management* |
| Personalisation | Acute response team (ART) | Sleep, mood and meds** |
| HoNOS PbR | RiO database | |
| Village to rail | Corridor psychiatry | |
| Experience to flexibility | Outcomes | |

| | | |
|------------------------|----------------------------|--|
| Short-termism | Service user involvement** | |
| Consumerism and choice | | |

*Theme extended from provisional code

**Satellite code positioned within more than one core code

The use of reflective memos enabled me to explore the relationship of the first cluster of core codes (pentimento strata) to the third set (the contemporary context of practice). This analytic work suggested, in addition to the pentimento layers outlined above, further strata were emerging as a result of institutional reforms to the mental health field in the UK. However while these new layers reflected three core codes: *market*, *managerialism* and *risk management*, the literature suggested a strong inter-relationship between the first two (Player and Leys, 2008; Law and Mooney, 2007; 2008). In the interests of theoretical parsimony I therefore integrated these within one overarching core code: marketisation. This formed an initial and, at this stage, highly provisional basis for an orienting conceptual framework with five layers: *confinement*; *biomedical gaze*; *systemic/community approaches*; *marketisation* and *risk management*.

This process of re-ordering the data was not as linear and unproblematic as the presentation here might suggest. This was in fact messy with numerous dead-ends and omissions. As noted some satellite codes are positioned within more than one core code. Moreover there were some provisional codes, presented in Table 5, which did not seem to fit within any of the new core codes. However, as Layder (1998) suggests, I sought to retain a broad range of provisional codes and openness to new ways of theorizing the data to avoid premature closure of the analytical process.

Table 5. Non-assigned provisional codes

| |
|-----------------|
| Chronic |
| Local knowledge |

5.3.5 Orienting concepts and the development of the interview schedule

Ethnographic data collection during the April – June 2010 period had involved further participant observation but also audio-recording of four ward rounds (see Appendix 2E) and five team meetings to enable funneling of data collection towards a focus on models for understanding mental distress in the contemporary service context.

Following this, from July 2010 I took a six-month break from fieldwork. This facilitated the opportunity both to conduct further data analysis and to develop tools and seek ethical clearance for the next stage of data collection: in-depth interviews.

The process of conducting pilot interviews with practitioners, service users and carers linked to the University of Birmingham enabled exploration of and reflection on conceptualizations of mental distress. In my initial interview schedule for the pilot, questions asked participants to articulate which models they used in practice. However, in the case of practitioners this approach tended to lead to a somewhat formulaic response linked to professional identity, and did not enable exploration of phenomenological practice gaps related to conceptualizations in practice.

Critical reflection on this issue pointed to the need to improve the operationalisation of theoretical models of distress within the interview schedule. This was achieved by utilizing the multi-dimensional understanding described in the Models Project (Colombo et al., 2003; Fulford and Colombo, 2004) in combination with critical realist conceptions of knowledge. The interview schedule (see Appendix 1J) was therefore structured around three sections to explore: theoretical knowledge, contextually-situated knowledge and the organizational and historical shifts in the context of practice (drawing on the orienting conceptual framework of the adapted pentimento).

The first section of the schedule sought to examine understandings of the service user's mental distress based on the three key dimensions elaborated in the Models Project (Colombo et al., 2003). These are: what is the nature of mental health difficulties (e.g. diagnosis/label and causes), what should be done about it (e.g. treatment/help and prognosis), and how should the people involved behave towards each other (e.g. the rights and duties of both service user and society). For practitioners this section was oriented around the mental health needs of service user participants in the study with whom I had observed the practitioner interacting in the role of caseworker. For service users and carers this part of the schedule was based around these strands but sought to examine how the interviewee conceived their own mental distress or that of the person for whom they provide care. In the case of all three participant groups, the processes for negotiating any differences of perspective with others were explored here.

The second section sought to examine practitioners' contextually situated knowledge through exploration of the meanings of frequently used terms such as 'chronic' and 'crisis'. The second section for service users and carers, and third for practitioners, addressed the impact on practice of the contextual factors in the organization of services related to various pentimento layers including biomedical or systemic approaches and more contemporary market and managerial reforms and risk management. The questions were framed throughout using accessible terminology.

I conducted the interviews between February and September 2011. The transcription and analysis of the interview data proceeded alongside this. The analytic work utilized the previously established core and satellite codes linked to the orienting conceptual framework of the adapted pentimento. However during the analysis I remained open to the potential for emergent provisional codes and a significant number of these were generated (see Table 6).

Table 6. Additional provisional codes from interview data

| |
|-----------------------------------|
| Interprofessional tensions |
| Negotiating explanatory positions |
| Negotiating interventions |
| CMHT-ward tensions |
| Diagnostic practices |
| Reframing risk |
| Monitoring |
| Observation |

| |
|-----------------------------|
| Time for reflection |
| Practice wisdom |
| Boundaries |
| Strengths perspective |
| Community engagement |
| Space |
| Social networks |
| Relationship-based practice |
| Short-term intervention |
| Responsibility |
| Outsourcing |
| Recovery |
| Service user movements |

However, on the basis of further analytic work to explore the relationship of these data to the core categories, a number of the provisional codes were re-categorised as satellites within the adapted pentimento and situated activity core codes. Tables 7 and 8 present these new updated core and satellite codes for the pentimento and situated activity clusters respectively.

Table 7. Updated Core and Satellite Codes: *Pentimento*

| CONFINE-MENT | BIOMEDICAL GAZE | SYSTEMIC | MARKETIS-ATION | RISK |
|---------------------|------------------------|-----------------------------------|----------------------------|-----------------------|
| Confinement | Biomedical gaze | Systemic/ community approaches | Marketisation | Risk management |
| | Sleep, mood and meds* | Integration | Personalisation | Sleep, mood and meds* |
| | Diagnostic practices | Encompassment | HoNOS PbR | Reframing risk |
| | Monitoring* | Exclusion | Village to rail | Monitoring* |
| | Observation* | Therapeutic intervention | Experience to flexibility | Observation* |
| | | Strengths perspective | Short-termism | Responsibility* |
| | | Community engagement | Consumerism and choice | |
| | | Social networks | Performance targets | |
| | | Relationship-based practice | Acute response team (ART) | |
| | | Inter-professional tensions* | RiO database | |
| | | CMHT-ward tensions | Corridor psychiatry | |
| | | | Outcomes | |
| | | | Service user involvement** | |
| | | | Short-term intervention | |
| | | | Responsibility | |
| | | | Outsourcing | |
| | | | Recovery | |
| | | | Responsibility* | |

*Satellite code positioned within more than one core code

Table 8. Updated Core and Satellite Codes: Situated activities

| STRATEGIC ACTION | RESISTANCE |
|-----------------------------------|-------------------------------|
| Strategic action | Resistance |
| Competition | Practitioner-manager tensions |
| Discretion | Humour* |
| Humour** | Service user involvement** |
| Conflict | Interprofessional tensions* |
| Coping strategies | Service user movements |
| Practice wisdom | |
| Boundaries | |
| Negotiating explanatory positions | |
| Negotiating interventions | |

*Satellite code positioned within more than one core code

Whilst much of the data could be assigned to these existing core codes, some themes did not fit within this framework. These are set out in Table 9. Interestingly, these highlighted the spatial and temporal dimensions of experiences within the practice context. Moreover data collection at this stage had also indicated the continuing salience of interdisciplinary forms of practice, knowledge and conflict within this domain. These two themes chimed with theoretical work I had recently embarked on, an exploration of the utility of Bhaskar and Danermark's (2006) notion of the laminated system that was introduced in Chapter 4. The ways in which the

concept of lamination proved useful in the analytic process will now be described in greater detail.

Table 9. Revised non-assigned provisional codes

| |
|---------------------|
| Chronic |
| Local knowledge |
| Space |
| Time for reflection |

5.3.6 Epistemological reconstruction: the pentimento as a laminated system

I utilized reflective memos to examine two particular questions arising from the interview stage of data collection and analysis. The first is the prominence of themes related to inter-professionalism. This emerged as a key process, but also intersected with the substantial data collected related to managerialist reform. I will present one of the segments of data (coded *inter-professional tensions*) that related to this in order to demonstrate the utility of the laminated system framework. CMHN Leslie, like many other practitioners regardless of discipline, described a shrinking space for therapeutic and relationship-based practice with service users as a result of managerialist demands. He explained:

[T]here's people in every community mental health team, social workers, CPNs [community psychiatric nurses] and OTs, who've got lots of skills and abilities to offer people, who are not being allowed the opportunity to do it at the moment, because... the complexities of care co-ordination, bureaucracy, funding issues and so on that we're getting bogged down in. (Leslie interview 2, p.11)

However Leslie noted, as did other participants in the study, that the profession of psychology seemed to have positioned itself more effectively than other groups to continue to offer a therapeutic orientation. He continued:

[P]sychology are very, very good, as I said earlier, at protecting their time [with service users] and the range of skills that they have to offer, they're able to offer the people, and in accessing funding for training and doing that training, kind of bringing those skills back to the workplace and to the client group, in the way that other professions are perhaps not. (Leslie interview 2, p.14)

This is one example of the way in which the bureaucratic exigencies of new public management seem to be simultaneously reshaping professional roles and also generating tensions within inter-professional relationships in practice. Here, the laminated system of scale assists in theorizing the interplay of these managerial and occupational processes. As noted in Chapter 4, I was able to re-describe such events in terms of the synchronic interaction of (i) occupational (interprofessional relations/division of labour) and (ii) organizational (managerialism and the reconfiguration of occupational roles) generative mechanisms at the *meso* ontological level (Bhaskar and Danermark, 2006; Porter, 1995). Using a retroductive approach, I posited this as enabled by the *macro* context of neoliberal welfare state reform, though also shaped and constrained by individual activity and resistance at the micro level.

The second question that arose concerned spatial and temporal themes emerging from the analysis of the interview data. In Chapter 4 it was argued that practitioners and their practice cannot be reduced to theoretical knowledge but must also incorporate practical or contextually situated knowledge. The latter is an important

condition for professional practice but requires a diachronic perspective as institutions are marked by change over time. An example of a segment of data that was assigned one of the uncategorized codes from Table 9, *local knowledge*, is where Crisis Team CMHN Simon uses this phrase to describe the accumulated understanding of and relationship to place built up by Leslie through working in mental health services in the immediate area for fifteen years. Simon expressed concerns that this community-based and geographically rooted expertise developed over a lengthy period was placed at risk by reconfigurations that ushered in a new short-termist orientation. Again, the laminated system proved useful in conceptualizing this kind of spatio-temporal emergence in terms of both the reproduction but also transformation of institutions over time.

However the utility of the pentimento as a spatio-temporal laminated system is also demonstrated by its capacity to account for practitioners' movement between ideological positions within the historically sedimented institution of the CMHT. As CMHN Bill explained:

[Y]ou'll get people [nurses] who are totally aligned with the medical perspective, medical model and you'll get people at the other end of the spectrum [...] more into kind of the empowering of the service user and the voice hearing movement and the more progressive, and I guess some, we're all, the rest of us are all on that continuum somewhere and I guess some of us move, it's not static.

When I asked Bill how he would position himself, he clarified that this would probably be determined by:

[T]he amount of distress that the person's experiencing, distress plus risk that kind of gauges where I'm, yeah, quality of life really, I suppose...[long pause]... yeah, it's really great to hear there are some people who can manage their illness to the extent where they can compartmentalise the voices and still

function well and you know, have that control over, that's brilliant, accepting that it's not everybody can. (Bill interview)

He went on to explain that his own movement between different positions on this 'continuum' would depend on the level of risk or distress experienced by the service user. For instance, were the service user to "go into the middle of the street and tear all their, take all their clothes off or something" then, for him, biomedical interventions would be justified.

Another salient feature that emerged here and frequently throughout the interview data is the role of service user/survivor movements in placing new forms of intervention on the practice agenda. This prompted the development of a final additional core code cluster of *service user involvement*. This meant that the number of pentimento strata increased to six: *confinement*; *biomedical gaze*; *systemic/community approaches*; *marketization*; *risk management* and *service user involvement*.

5.3.7 The pentimento as adaptive theoretical framework

At a relatively late stage of the analysis, an iterative movement between the analytic ideas emerging from the newer interview data and extant theory Contributed to two final major adjustments to the adaptive theoretical framework. The first of these concerns the decision to integrate three core codes to create one overarching stratum of neoliberalism, and the second concerns the epistemological reconstruction of the pentimento. These will now be explained in more detail.

In relation to the first, the interview with Bill was just one example that highlighted a broader trend in the data. In the interview a stark contrast emerged between the 'involved' service user who self-manages effectively and responsibly, warranting collaborative social interventions such as the hearing voices approach that have gained prominence via movements of users and their allies, and the 'risky' service user where concerns about possible danger legitimize a shift to a biomedical mode and an implicit turn to greater coercion. It was at this point that the model of responsibilisation proposed by Brown and Baker (2012) outlined in Chapters 3 and 4 provided me with a useful orientation to the data. As noted there, within the neoliberal welfare regime service users face greater pressure to accept responsibility for self care with fewer resources, while those unable or unwilling to do so are subject to more coercive forms of intervention. In light of this, I re-examined the core and satellite codes. These were then reconfigured under one *neoliberalism* core code but with three inter-related dimensions: marketisation of services, risk and coercion and service user involvement and consumerism (see Table 10). Warrant for this theoretical reconstruction was provided by factors such as the positioning of satellite themes like 'responsibility' across the three core codes. Further justification is offered through evidence presented via the case studies in Chapters 6 and 7. This iteration of the adaptive theoretical framework seemed to possess greater parsimony and the appropriate analytical purchase.

The second of the adjustments to the adapted pentimento framework was facilitated by this first development. Reflection on the emergent neoliberal welfare regime as a

new pentimento stratum prompted me to return to a question of the potential for tensions between the epistemological and ontological assumptions underpinning Rhodes' pentimento and those of CR. As noted in 4.5.1, I then drew on Archer (1995) and Bhaskar (1998) to epistemologically reconstruct the pentimento. This involved a shift from the Foucauldian discursive conception of layered meanings in Rhodes to a critical realist ontology of strata as relatively enduring conjunctural welfare settlements shaped by socio-historical processes. Consequently the adapted pentimento strata were renamed: *custodial system*; *biomedical treatment system*; *community care system*; and *neoliberal market system* (see Table 10). While this was the final form taken by the adaptive conceptual framework of the pentimento for the purposes of the thesis, Layder (1998) cautions against considering adaptive theory as end-point or definite conclusion to theory building. The data assigned to non-allocated codes highlights potential tensions and aporia in this model. The reconstructed pentimento should therefore be seen as provisional, and open to revision and reformulation (or rejection) in response to new empirical evidence and conceptual developments.

Table 10. Final Core and Satellite Codes: *Pentimento Strata*

| CUSTODIAL | BIO-MEDICAL | COMMUNITY CARE | NEOLIBERAL SYSTEM | | |
|------------------|-----------------------|-------------------------------|----------------------------|-----------------------|----------------------------|
| Confinement | Biomedical gaze | Systemic/community approaches | MARKETISATION | RISK | SU INVOLVEMENT |
| | Sleep, mood and meds* | Integration | Marketisation | Risk management | Service user involvement** |
| | Diagnostic practices | Encompassment | Personalisation* | Sleep, mood and meds* | Service user movements |
| | Monitoring* | Exclusion | HoNOS PbR | Reframing risk | Responsibility* |
| | Observation* | Therapeutic intervention | Village to rail | Monitoring* | Personalisation* |
| | | Strengths perspective | Experience to flexibility | Observation* | |
| | | Community engagement | Short-termism | Responsibility* | |
| | | Social networks | Consumerism and choice | | |
| | | Relationship-based practice | Performance targets | | |
| | | Inter-professional tensions* | Acute response team (ART) | | |
| | | CMHT-ward tensions | RiO database | | |
| | | | Corridor psychiatry | | |
| | | | Outcomes | | |
| | | | Service user involvement** | | |
| | | | Short-term intervention | | |
| | | | Responsibility* | | |
| | | | Outsourcing | | |
| | | | Recovery | | |

*Satellite code positioned within more than one core code

In summary, this section has provided an overview of data analysis, noting the value of adaptive theory and orienting concepts in this process. The application of the latter has facilitated the development of theory via the extension of Rhodes' pentimento.

5.3.8 Documentary analysis

The types of documentary data collected are noted in Appendix 2H. Case record data was collected at a relatively late stage due to the need for additional ethical clearance. Consequently, due to the volume of data gathered and constraints of time a pragmatic decision was made to conduct detailed analysis of case record data only in relation to the two case studies presented in Chapters 6 and 7. The process of analysis of these data followed the same procedures as other textual data collected for the study.

5.3.9 Presentation of the data

This section explicates the rationale for the selection of particular segments of the data set to elucidate the key themes and theoretical framework of the study.

The process of writing up the study as an ethnographic text involves the reconstruction of social actors, activities and the contexts within which interaction takes place. A large quantity of data was collected during the course of the study that would be impossible to present in its entirety. The central emergent themes and

theoretical ideas of the study are therefore illustrated in three chapters. The first two, chapters 6 and 7, take the form of detailed case studies of 'crisis scenarios'. These are temporal narratives that describe the interventions of CMHT and other mental health practitioners with two service users: Manu and Alistair. The other, chapter 8, provides a general overview of the convulsions and resistance generated by neoliberal restructuring of the CMHT setting. In order to understand the reason for the selection of these particular case studies from an extensive data set an initial explication of the central role played by retroduction is necessary.

As noted earlier, phenomena exist in open systems where a number of mechanisms may be interacting and crosscutting in complex ways. Because of this characteristic of the social world in which research is conducted, the traditional experiment that relies on a closed system is not feasible. As a result CR argues that an alternative retroductive approach is required which seeks to establish the basic conditions (the structures or relations) that make the particular phenomenon that is being studied possible.

There are a number of modes for facilitating retroductive inferences, but for the purposes of the present research what Danermark et al. (2002, p.104) describe as the study of 'pathological²⁰ circumstances' of a phenomenon is the most relevant. This is where the mechanisms in operation in a setting become more clearly visible to participants (and researchers) than under normal settled conditions because of disruptions to the functioning of typical processes. Collier (1994) (cited in Danermark

²⁰ It is important to note that this refers to pathology within the environment and should not be associated with individual pathology in a biomedical sense.

et al., 2002) refers to this approach as 'the methodological primacy of the pathological'. As Bhaskar (1998, p.48) (cited in Danermark et al., 2002, p.104) notes:

It might be conjectured that in periods of transition or crisis generative structures, previously opaque, become more visible to agents. And that this, though it never quite yields the epistemic possibilities of a closure [...] does provide a partial analogue to the role played by experimentation in natural science.

I will now explain two ways in which this injunction to study pathological circumstances in order to retroduce the most salient generative mechanisms has been of particular utility to the present study.

The first concerns the choice of the two case studies of 'crisis situations' to illustrate the key themes of the thesis. These crisis scenarios must initially be contrasted with the 'non-pathological'. In the context of Southville and Northville CMHTs this means the typical daily work of practitioners. Such work involves supporting service users to maintain stability in terms of their mental health with the aim of avoiding hospital admissions. The importance of this latter goal was emphasised one week at a CMHT meeting where deputy manager Filipe praised the team effusively when it emerged that there had been no new admissions the preceding week. The vast majority of Southville and Northville CMHT service users, including most user participants in the study remained resident within the community and were not admitted to hospital during the entire period of the study. As a result, there tended to be infrequent inter-professional interaction in relation to this service user group. Typically the care co-ordinator (CMHN, OT or social worker) would provide the only regular contact from a CMHT worker (every two to six weeks), with considerably less input from the consultant or other psychiatrist (often only the annual CPA meeting). In this context

the professional division of labour would remain more clearly and predictably demarcated with medication review by the psychiatrist and treatment monitoring and social inclusion responsibilities allocated to CMHNs and social workers.

However, in the event of a service user experiencing a mental health crisis inter-professional decision-making and joint working would become more intensive. This group of service users would tend to be discussed more often, sometimes at length, in the office and during team meetings. The two case studies, of Manu and Alistair, were chosen for detailed presentation in the thesis because both service users experienced mental health crises involving protracted periods of in-patient admission. The type and intensity of inter-professional support they received was not, therefore, representative of that typically offered by the team. However these two 'crisis situations' heightened the visibility of mechanisms related to understandings of mental distress enabling the research questions for the study to be more effectively addressed.

Moreover there was also a pragmatic dimension to this selection insofar as these two crisis scenarios were amongst the small number of case clusters where, as well as field note and meeting transcripts, interview data had been collected from more than one practitioner enabling comparison and contrast of multiple perspectives in relation to Alistair (service user, carer, social worker and psychiatrist) and Manu (CMHN and psychiatrist²¹).

²¹ The reason that interview data were not collected for Manu and his carer will be explained in the following chapter.

The second of these critical situations related to the effects of the reconfiguration of the CMHT setting. The introduction of new structures for practice engendered a sense of crisis amongst practitioners, as the comments above from Bob and Farooq illustrate. They felt that established routines, requirements of the role and ways of thinking were undermined. However these disruptions brought into clearer view some of the taken for granted assumptions and habitual orientations within the setting enabling more effective discernment of the preconditions and mechanisms underpinning established forms of practice and conceptualisation. It is for this reason that Chapter 8 provides an overview of this process of reorganisation and resistance at Southville CMHT.

Having provided the retroductive rationale for the selection of these particular case studies the chapter will move on to identify issues that impacted on the quality of the analysis.

5.3.10 Issues affecting the quality of analysis

This section will explore what constitutes good quality in qualitative research and how possible threats to the validity and trustworthiness of the findings of the present study have been managed.

The first set of potential threats to validity is identified by Maxwell (2012) who describes a three-fold typology for ways of understanding within qualitative research: description, interpretation and theory. Threats to descriptive validity may arise from

inaccurate or incomplete data. For this reason I took contemporaneous scratch notes where possible, and typed up comprehensive field notes on a daily basis. I supplemented my field notes with audio recordings of meetings and interviews to enhance accuracy. Threats to interpretative validity have been addressed by providing, in this chapter, an audit trail of interpretations of the data to chart the steps taken in this analytic process. Threats to theoretical validity have been attended to via demonstration of how the orienting framework of the pentimento was adapted in light of data collected and how alternative conceptual frameworks for explaining the phenomena such as that of Sennett (2006) were considered.

In addition, Robson (2011) has proposed strategies to address the further challenge of bias and to demonstrate rigour. I have sought to reduce reactivity and respondent bias in the study through a prolonged period of fieldwork in order to become accepted by participants and develop trusting relationships. I noted above that I managed the threat of researcher bias ('going native') by periods of withdrawal from the field and use of supervision. Moreover data triangulation was utilised to enhance the rigour of the research, with data collected via observation, interviews and documents.

However, on reflection there are additional procedures that were not adopted that may have further enhanced the validity of the findings. The first is member checking (Robson, 2011). In this instance I might have gone back to participants to test the usefulness of the emerging theory from the perspective of people in this practice field (Kempster and Parry, 2014 p92). Second, though I considered alternative theoretical

frameworks during analysis I did not engage in a systematic negative case analysis and this may have improved theoretical validity (Maxwell, 2012). Third, whilst the threat of reactivity and respondent bias was relatively successfully managed in relation to practitioners, I was not able to spend extended periods with service users and carers to build relationships and this therefore poses a threat to validity in this area (Robson, 2011).

The chapter will now move on to its final section where issues pertaining to ethical conduct and political orientation in fieldwork will be considered.

5.4 Ethical and political considerations

The adoption of a reflexive orientation in this study has necessarily drawn attention to the ethical and political dimensions of fieldwork (Davies, 2008) and these will now be considered. The first section will elaborate three particular challenges for the ethical conduct of ethnographic research relating to issues of: consent, beneficence, and justice (Zavisca, 2007). Developing a discussion introduced as part of my MA dissertation drawing on data from the pilot study (Moth, 2008a), I will consider some of the tensions and complexities in the operationalisation of formal ethics procedures and codes. I will then propose an alternative approach to ethical research practice that is more sensitive to issues of power and context. This leads, in the second section, to a brief discussion of the broader ethical and political implications of the methodology.

5.4.1 Ethics

The study was granted ethical approval by the University of Birmingham and a local NHS Research Ethics Committee (REC). The REC process legitimately directed my attention to a range of salient ethical concerns such as the need to preserve the anonymity and confidentiality of participants, to inform participants of their right to decline or withdraw from participation at any time and requirements around the sensitive handling of the data collected. There is, nonetheless, a tendency in such procedures to reduce ethical considerations to standardised formulae predominantly oriented to the preservation of confidentiality and minimisation of risk (Moth, 2008a). While these are necessary, they are not sufficient conditions for ethical research practice (Hallowell et al., 2005). I will explore these deficiencies by examining procedures followed and some tensions and dilemmas related to these with regard to confidentiality, anonymity and informed consent during the study.

During the conduct of the study assurances were given to participants that all data collected during the course of the research would remain confidential, and recorded information would have names removed so that individuals would not be recognizable (see Appendices 1A – 1H). The following section will seek to specify in practical terms the meaning and limits of anonymity and confidentiality for this study.

Steps taken to preserve confidentiality included the data being accessible only to the researcher, and stored on a password-protected computer. Signed consent forms were kept by the researcher in a locked cabinet and participants' names were

removed from electronic data and replaced by an identifying code, except for one file that linked participants' names to their code. However this latter file was stored separately from the other data in a secure password-protected environment.

The matter of confidentiality is closely related to that of ensuring anonymity. To achieve this latter goal, when presenting data in the thesis I have removed identifying characteristics of specific participants such as name, location and nationality from which identities could be inferred. Service users' and carers' occupations have also been changed. However it would not be possible within a small-scale, context-rich qualitative study such as this to change the professional affiliations of practitioner participants in order to disguise identities without changing the meaning of the data and undermining its utility in addressing the research questions (Parry and Mauthner, 2004).

Moreover protecting anonymity remains challenging within small-scale research settings such as CMHTs where members of teams may recognize colleagues or service users from features such as linguistic habits even where other details are changed. Decision-making in relation to this particular dilemma for the study, that of balancing the protection of participants' identities with the integrity of the data, is one which as Wiles et al. (2006) note is dependent on the possible harm arising from identification. My intended strategy for the management of such risks as I move towards wider publication include minimizing the use of extended verbatim quotations that may make participants more readily identifiable, and meeting and working with key participants to explore the possible consequences of disclosure.

I will be cognisant of the above issues as I make arrangements to provide feedback on the study to participants, a key ethical commitment. I intend to develop both presentation materials and also a summary of the key findings from the research to facilitate this. The summary will be provided to all those that requested it during the fieldwork process, and written in accessible language. In addition, I will return to the relevant teams in the Trust²² and offer to give a presentation of the findings to practitioners. I will also work with the user involvement and carers' group co-ordinators to arrange presentations for service users and carers.

Another important issue for the conduct of ethnographic research is that of informed consent. In line with the agreed REC procedures, I gave all prospective participants (practitioners, users and carers) an information sheet when they were invited to participate, the opportunity to ask questions and emphasised their right to decline. Before starting data collection with the CMHTs I had several meetings with team members to explain the focus and methods of the study, answer queries and secure collective consent. I also met with all team members, including administrative staff, individually once fieldwork had started to seek individual consent and collect completed consent forms.

There were, though, complexities and dilemmas to navigate to ensure ethical practice in this NHS setting. Prospective service user and carer participants were approached via their CMHT care co-ordinators or psychiatrist. I would then meet with

²² The CMHTs within which the research was conducted have now been restructured so the relevant reconfigured teams and practitioners will be approached.

the service user/carer individually to provide written and verbal information about the study and emphasize that declining to take part would not impact in any way on their access to services. However the role of care co-ordinators or psychiatrists as gatekeepers may have been experienced by service users as a subtle form of pressure to agree to participation. A second issue is the contradiction between an assurance of confidentiality and the signing of consent forms. For instance, one service user agreed to participate in the study after I had engaged in lengthy discussion with him and he had read the information sheet. However, when I offered him the consent form to sign he declined. He pointed out that this would constitute evidence of his participation and thus undermine the assurances of confidentiality. He noted that he was willing to participate but without signing. I explained that strict conditions for data storage were in place but these were not sufficient to reassure him. As a result I decided not to include him in the study, which raises a question of whether such procedures are designed to protect participants or the institutions within which research takes place.

A related issue is that of securing the informed consent of those attending meetings. In relation to ward rounds, all staff, service users and carers were approached before the meeting to seek consent. Several service users and carers, though no staff members, declined to participate and therefore were not included in the study. However some data were collected outside of the usual team/ward setting for the study, for example at trade union or managers' meetings. This presented difficulties with regard to securing consent in advance (sometimes I was invited along by team members at short notice). In such cases, where the meeting was relatively small and

it was feasible to do so, I sought the consent of all participants by approaching them individually or collectively on arrival but before the start. I would provide information sheets and consent forms for these prospective participants to read and answer questions, after which I requested the return of signed forms from those willing to participate. If this was not possible at the beginning I would do so at the end of the meeting. However where the event was on a larger scale, I approached those participants whose contribution had been of particular relevance with an information sheet and sought signed consent at the end of the meeting. Had consent not been granted I would not have written up the data from my scratch notes relating to that participant in my field notes, but in every case such consent was in fact forthcoming. This approach necessitated a supply of information sheets and consent forms to be carried with me at all times during the fieldwork.

However complex issues are raised by the way in which REC procedures tend to construct consent seeking as a one-off event. For example, does the fact that a practitioner signed a consent form weeks earlier serve to legitimise my noting 'off the cuff' comments made in the informal setting of the pub when the participant perhaps considers I am 'off-duty'? This subsequently intensified as my relationships in the field developed and deepened over the extended period of fieldwork because participants exhibited less caution in terms of personal and professional disclosure. In such circumstances a process of gaining sustained consent is more appropriate form of ethical practice (Zavisca, 2007). However, having established positive working relationships with Southville team members during the main period of fieldwork, on occasion my enquiries to re-establish that participants wished to

continue engagement in the study were met with confusion or mirth. However, this state of affairs contrasted significantly with that during the pilot study with Northville CMHT, when nurse practitioners were initially reluctant to actively engage with the study even though all had signed consent forms. I wondered whether their actions constituted a tacit withdrawal of consent, meaning I should withdraw from the field. I seriously considered discussing this disengagement at a team meeting to try and negotiate a resolution. However, I later understood from informal discussion and observation that the background to this was disenchantment with managerial arrangements. In this team both managers were social workers in breach of a convention within the Trust where the standard practice was that managers and deputies would be drawn one from each of these occupational groups. My identity as a social worker seemed to reinforce the dissatisfaction amongst this group. In this context, I reflected that an intervention at a team meeting might be counterproductive, and perceived to be recruiting management support to place pressure on these practitioners thus reinforcing the unequal power dynamics within this domain. So, instead, I resolved to carefully work on building trust with members of this group.

This issue prompted further reflection on power dynamics in this setting. The activities of senior managers structure the experiences of frontline practitioners and service users alike in significant ways. I therefore sought consent to observe managers' meetings in order to explore this issue further. I initially encountered difficulty in securing institutional agreement and the refusal of this request would have closed off the possibility of exploring important processes shaping mental health practice in this setting. The requirement for informed consent might thus have

enabled powerful organisational actors to elude scrutiny. However I persisted and was eventually granted permission from senior executives within the NHS Trust²³. This highlights the need for ethical considerations to be contextualised within an understanding of the relative power relations of participants and researcher (Hornsby-Smith, 1993).

In light of this I will argue that a more satisfactory account of ethics in research practice is one that is context-sensitive, considers the ethical dimension to be embedded within all social interactions and is oriented to values such as social justice (Hallowell et al., 2005). Hammersley and Atkinson (2007) characterise the practice of ethnographic research as 'judgement in context', and ethical research practice requires similar situational decision-making rather than adherence to formal and prescriptive codes. I recognized from my own previous role as a social worker, and in the everyday dilemmas described by the practitioners with whom I conducted the study, that a requirement to engage in ethical decision-making articulates tensions between competing obligations towards individual rights and broader societal considerations and reflects the power relations in which the actors are always enmeshed. There are thus significant parallels with the experience of the ethnographer who is also constantly involved in an ethical 'balancing act' (Hallowell et al., 2005).

The issues of ethics and politics of social research are intimately interlinked (Davies, 2008). Scheper-Hughes (1995, p.417) has problematised the moral and cultural

²³ Formal individual consent was requested from all participants at the managers' meeting.

relativism associated with the postmodern turn in ethnographic and anthropological practice, arguing that it produces research characterised by political quiescence. In response she proposes an alternative morally and politically engaged ethnography. Such an approach recognises the partial, incomplete and fallible nature of the ethnographic researcher's interpretations, but argues that by utilising careful observation and empathic listening to research subjects a 'good enough' ethnography that has the potential to constitute an act of solidarity with informants can still emerge.

The discussion above of identity in the field raised the issue of the political positioning of the researcher. Political and ethical considerations are inextricably bound together, but while the ethics of research always involve moral commitments to others, the nature of such judgements is complex and should be contextualised politically. I concur with Armbruster's (2008) view that questions of the locus of ethics relate to evaluations of the locus of power: we negotiate preferential loyalties situated in our own moral and political convictions. Consequently, contra the neutral stance advocated in positivist science (Burawoy, 2008), ethical research practice involves taking sides. Lindisfarne (2008) urges the researcher to stand in solidarity with the social struggles of ordinary people, using the example of democratic psychiatry in Italy, where the 'negative worker' was enjoined by leading figure Franco Basaglia to stand against powerful institutions and on the side of the patient (Scheper Hughes 1995).

This study seeks to make its own modest contribution to this tradition of engaged research. In elucidating the relationships between contemporary reconfigurations and forms of knowledge in the statutory mental health field the study aspires not only to be descriptive but, through the identification of causal mechanisms, to indicate potentialities in the field for forms of political agency and resistance. It is hoped that these might inform current debates amongst practitioners, their organisations such as trade unions as well as service user/survivor networks and movements.

5.5 Summary

In conclusion, the chapter has described the methods utilised, with a particular focus on the analytic process and deployment of adaptive theory and orienting concepts to facilitate the development and elaboration of theory via an extension of Rhodes's *pentimento*. The importance of a contextually situated ethical perspective that is sensitive to power relations in the field has also been noted and this has been framed within the broader political and ethical orientation of the study. Having provided an overview of methodology, the thesis will now move on to presentation of data and findings from the study.

Chapters 6 and 7 have been removed from repository version
of thesis

8. SOUTHVILLE CMHT

8.0 Introduction

This chapter will provide greater context for the themes detailed in the case studies in Chapters 6 and 7 by providing an overview of the impact of the neoliberal stratum and attendant reconfigurations of practice at Southville CMHT. The first section will introduce the team members. The second will examine ways in which these practitioners perceive the practice environment to have changed as a result of recent policy developments and reorganisations. The following section will consider the dominance of biomedical and risk perspectives within this setting and consequent impact on the articulation of social perspectives. The fourth section will describe some emergent forms of resistance to these processes.

8.1 Southville CMHT team members: a brief sketch

Three practitioners working at Southville CMHT: James, Abbie and Filipe, have already been introduced in Chapters 6 and 7. In this section I will present other team members who appear in this chapter. Names and some other minor details have been amended to disguise identities.

Eve is Southville CMHT manager. She is an experienced and long serving community mental health nurse practitioner having trained in the 1970s. Eve worked

first with people with learning disabilities and then moved into mental health nursing. She identifies her practice as strongly informed by narrative therapy and utilises these approaches in the Mental Health Matters workshops she co-facilitates with practitioner and service user colleagues. Eve was described by one nursing colleague as an 'old school manager' both because she was unusual amongst her CMHT manager contemporaries in retaining a small caseload of service users, and due to a supportive and mentoring approach to her team that contrasted with an emergent target-driven culture in the NHS. Eve is of white British ethnicity.

Roger is an experienced community mental health nurse. He qualified thirty years ago, and worked for his entire career in the local area, initially within in-patient services then six years later moving into the community setting. He is soon to retire. Roger is well known for his political commitments. He was an active and militant trade union representative, leading industrial action against redundancies within the forerunner of the Trust in the early 1990s, though he expresses frustration at the current paucity of action by his UNISON (trade union) branch. Roger is from a white British background.

Kath is a community mental health nurse who qualified twenty-one years ago in 1990. She has worked at Southville CMHT since 1998, though she took five years out for maternity leave. The idea of working in mental health nursing had grabbed her imagination whilst studying for her psychology degree, and as a result she wrote her Goffman inspired undergraduate dissertation on institutional interactions whilst

working in a care home. However what was also important in this career choice was that it offered a stable, reliable job and income. Kath is of white British ethnicity.

Leslie is a community mental health nurse who trained while still in his teens during the 1980s. He followed in the footsteps of many others in his family by going into public services. He has worked continuously in the mental health field since then and, like Kath, has been at Southville CMHT since 1998. Leslie is a longstanding advocate of 'hearing voices' and other critical approaches. However, when mentoring nursing students, he considers it important they develop a good understanding of the biomedical model before engaging with alternatives. You have to "construct before you deconstruct," he once explained. Leslie is of white British ethnicity.

Bill is a community mental health nurse, who trained in the late 1980s and after a brief period as an in-patient nurse moved into community mental health in the early 1990s. He has worked for his whole career in the local area apart from a short career break in the 1990s to travel in Asia. Bill is also an avid cyclist and of white British ethnicity.

Yvonne is a social worker who has been qualified for eleven years. She has worked at Southville CMHT for ten years and completed her AMHP training two years ago. She worked for one year in children and families' social work before realising that she was becoming too 'emotionally involved' and so decided to switch to mental health. Her decision to train in social work was originally influenced by her role caring for her grandmother when she was a child. Yvonne is of black British ethnicity.

Ruth is a social worker who qualified ten years ago, gained the post at Southville CMHT and has worked there since. During this time she also qualified as an AMHP. Ruth first developed an interest in mental health through her psychology degree. After the degree she worked for several years in mental health housing, but felt she needed to progress. However she did not want to go into management and therefore decided to train as a social worker. Ruth is from a white British background.

Constance is a social worker who also qualified ten years ago and had recently completed her AMHP training. She has been with Southville CMHT for eight years and prior to that worked at voluntary sector organisation MIND as a mental health advocate. Before her training Constance worked with children who were care leavers. She studied social work as a mature student and found this to be a life-changing experience. She is of black British ethnicity.

Farooq has worked as a social worker in the Southville team for the last five years and recently qualified as an AMHP. His first involvement with Southville CMHT came ten years ago, when he was placed within the team to collect data for a study concerning the British-Pakistani community's access to local mental health services. Following the end of the study he decided to stay on as a support worker to help implement the findings of the study. He then went on to train in social work. Farooq is originally from Pakistan and came to the UK 10 years ago.

Kerry is an occupational therapist. She qualified in 1992 and has worked for most of the time since in mental health in-patient settings. However Kerry has been at Southville CMHT for the last six years and joked that this is the longest she has worked anywhere. She has just completed training as an AMHP.

There are several other study participants also included in this chapter. Phil is a CMHN based at Southville CMHT on a temporary contract. Derek and Terry are Assistant Directors in the Trust. Terry is line manager for Eve at Southville CMHT, and Derek has the same role for Northville. Also mentioned are Simon, a community mental health nurse based at the local Crisis Resolution Team, and Alan, a social worker based in another CMHT in the Trust, who is the UNISON trade union representative for Southville CMHT social services staff.

Having introduced these participants, I will now move on to elucidate some effects of the reconfiguration of practice at the CMHT.

8.2 The transition to neoliberal service provision

The Service Line Management (SLM) restructure announced during the course of my fieldwork to facilitate the introduction of payment by results constituted a tipping point in the transition to a neoliberal service format. In this first section Southville CMHT practitioners' experiences of this process will be examined and related to the neoliberal stratum of the pentimento.

On my initial visit to Southville CMHT, I was given a copy of the 'CMHT Report' compiled by team manager, Eve, a couple of years earlier. While this document provided a statistical and demographic overview of the population served by the CMHT it also included a section entitled 'Staff Team'. Alongside a breakdown of the training undertaken and particular roles of team members, this section, written in a conversational and informal style, mentioned team members' parental and other caring responsibilities, for instance: 'Kerry [OT] will be returning soon after spending the first year with Lucia [newly born daughter]. Kath [CMHN] has returned after a career break, as Karl and Tom [her sons] are now more independent and well ensconced in their school careers.' This evoked the continuity within the setting and relatively longstanding team membership of most of the practitioners.

However, the team was now facing another restructure following only three years after the last major reorganisation of CMHTs. Practitioners experienced this culture of short-termism and incessant organisational change as undermining attempts within the team to sustain supportive and mutual structures and relationships. The Caius Petronius quote attached to the door of the office (noted in Chapter 7) that bemoaned the demoralisation produced by constant reorganisation captured the prevailing mood amongst practitioners.

Competition was a new feature of this emergent neoliberal service culture. This began to infuse the relationships between teams, with performance indicators utilised to measure and compare one team's activity against another. Practitioners were concerned to avoid the ignominy of a poor placing in the CMHT league table for

prescribed targets and the potential sanctions (financial, disciplinary and reputational) for failure to meet them. Competition also became apparent in practitioners' talk about how their skill set (or practice 'toolbox' as Abbie put it) compared with that of others in the team and whether this would be sufficient to retain their job as they competed for a reduced number of posts after the reorganisation (Fieldnotes 3.2.11).

The primary medium for performance measurement was via data entry by practitioners. At a Southville CMHT meeting for members of the local authority branch of the UNISON trade union, the union representative, social worker Alan, described the demands on him to "feed the beast" in the context of the organisation's seemingly insatiable appetite (Fieldnotes 18.6.10). Similarly, at one team meeting, manager Eve described the disregard for the aspects of practice that could not be captured on the new electronic record system, commenting that commissioners, "don't believe in the spoken word anymore, evidence is only what's on RiO." She later surmised that the Trust only value "what is measurable" rather than "measuring what is valuable" (Fieldnotes 24.3.10). As a result, at one stage, the team was instructed to cancel all non-urgent service user contact for two weeks in order to concentrate on inputting data to meet targets (Fieldnotes 24.3.10).

The environment was consequently reshaped to facilitate the conditions for efficient data production. When the new hot desk arrangements proposed to follow the restructure were announced Eve described them as 'like a factory' with people squeezed together in rows (Fieldnotes 22.4.10). These examples illustrate the effects of strenuous welfarism noted in Chapter 3, in particular the tensions emerging from

managerialist strategies for the transformation of the tacit knowledge of mental health practitioners into codified forms subject to audit and control.

Demands for greater flexibility were also visible. Assistant Director (AD) Derek criticised the limited 'nine to five' opening hours of CMHTs at a managers' meeting. He compared this to an 11am appointment with his GP which would mean his "day is finished", and reminded the meeting that banks used to close at 330pm. "That was great for me," came the retort from Patti [deputy manager of another CMHT] "I used to work in one [a bank]" suggesting her opposition to such changes (Fieldnotes 12.2.10).

In this transition, practitioner experience too was no longer seen as a vital resource. Crisis Team CMHN Simon worriedly mentioned to me his concern that the Trust was discussing deleting the Band 7 grade for senior nurses as part of the reconfiguration to save money. He explained that practitioners like Leslie (CMHN) had what he described as immense "street knowledge" built up over many years of both local services and the needs of users, but he felt the Trust no longer valued this (Fieldnotes 13.5.10). Similarly, at the end of one team meeting Bill ironically commented on the Trust's shift towards recruitment of lower band NHS staff, "if nurses are just sitting on a computer all day then they don't need experience" (Fieldnotes 23.3.10).

These reductions in staff terms and conditions that accompanied the transition to a more fully marketised model were discussed at a UNISON trade union meeting for

health staff. The mood was one of frustration and uncertainty laced with occasional moments of humour, a strategy to cope with the debilitating effects of organisational power (Griffiths, 1998), as the following extract illustrates:

Karina [admin]: how do you integrate mental health into that [private] model?
Simon [CRT CMHN] (with sarcasm): They'll move to community and private contractors so it'll be a bit like Brixton market, going to buy your fruit and veg (all laugh)
Francis [Unison chair]: more like John Lewis [reference to Labour policy proposal] (more laughs)
Roger [CMHN]: (looking frustrated) But what do we do about it [reduction in terms and conditions]? (Fieldnotes 23.3.10)

Roger's question articulated, he explained to me later, a desire for collective action in response but he felt the union branch was failing to facilitate this.

The culture and consequences of the neoliberal model of SLM provision are also apparent in AD Terry's comments at the SLM launch event, where he explained that service lines now constitute 'business units', and that the Trust was seeking to gauge whether it was positioned 'as a market leader' in this new competitive environment (Fieldnotes 12.11.09).

The predominant response to these developments was one of anger and fear. Leslie, a CMHN, felt 'dispirited' and explained that he had reached the point where he thought: "Fuck the mortgage and go and work in Tesco's [supermarket]... sorry for the language." Kath (CMHN) laughed with the others at this, but commented anxiously under her breath "fuck the mortgage?" In a tone of bitter irony Bill added, "You'd have

more contact with the public in Tesco's" (Fieldnotes 23.4.10). However, forms of resistance were also visible and will be discussed further below.

Perhaps the most poignant symbol of this painful transition to an individualised neoliberal service model was the loss of the term 'community' from the name of this mental health team. Under the restructuring plan Southville was to be renamed a 'recovery and rehabilitation' (R&R) team. Eve expressed regret about this. It seemed this change in nomenclature was problematised as representing not just a new label but a more fundamental shift away from an ethos of community provision.

An example of this was the 'walk-in' centre, which Eve had formerly managed and that had been closed by the Trust two years earlier after a vociferous and lengthy campaign to keep it open involving a number of service users (Fieldnotes 28.4.10). Unlike the services of the CMHT, which can only be accessed via referral, or the locked door of the ward, the walk-in centre had an open door policy to those experiencing mental distress in the local area. To Eve and Roger, who had actively supported service users in their campaign, the loss of this space seemed to represent a turning away from the community, a metaphorical and literal closing of the door to the surrounding environment and its residents. Moreover the walk-in mobilised a form of collective engagement that is now marginalised in a context of increasingly individualised conceptualisation of and provision for those experiencing mental distress.

The walk-in thus seems emblematic of the transition from community care to neoliberal stratum, of which the shift from CMHT to R&R team is another expression. Turning to me towards the end of the fieldwork, Roger suggested my research would be a record 'for posterity' as the CMHT model entered its "death throes" (Fieldnotes 26.5.10). He considered this archive to be crucial nonetheless. Perhaps we might infer from Roger's comment the importance of *remembering*. This, Fisher (2008) argues, is a necessary act of resistance as the condition of ontological precarity produced by the perpetual institutional change and instability of neoliberal capitalism becomes an endemic feature of social experience.

Sennett's (2006) model of the culture of the new capitalism was useful in examining these processes. Sennett (2006) argues that the micro-situational level of the contemporary workplace has been shaped in particular ways by the macro processes of neoliberal capitalism. He describes the transition of the workplace from a *village*, constituted by relatively settled relationships to *rail station* where workers 'pass through', *short-termism* dominates managerial strategy, and *flexibility* is substituted for experience. These seem to evoke some of the emergent tendencies that were experienced (and resisted) by Southville workers.

8.3 The prominence of biomedical and risk perspectives and resistance to these in the context of the neoliberal transition

The processes described in this neoliberal transition had a number of significant effects on the practices enacted and concepts utilised by practitioners. Many of these

have already been outlined in detail in Chapters 6 and 7. This section will seek to expand on these to examine the effects of the neoliberal stratum, in particular the way that the meso level organisational processes of 'strenuous welfarism' (introduced in Chapters 3 and 4) associated with this stratum tend to remobilise biomedical orientations in spite of a shift in policy rhetoric and professional discourse towards more person-centred and socially oriented perspectives.

A common theme expressed by practitioners, as noted above, was the 'overwhelming' emphasis on data collection to the exclusion of face-to-face work with service users. These are consistent with the 'strenuous welfarism' model of neoliberal managerialism (Law and Mooney, 2007; 2008). Leslie described feeling like he was "working for stats" rather than with service users (Fieldnotes 24.3.10). He later explained, "the process of recording the job has become the job" (Leslie interview 1). Roger shared a similar view, arguing that he has "a relationship with the computer now, not with patients," (Fieldnotes 24.3.10), while social worker Ruth commented with bitter irony that she was considering recording the following office voicemail message: "I can't get to the phone now or see patients because of my new role as data inputter for Rio" (Fieldnotes 11.11.09). James expressed concern that the computer had become an additional presence, part of "a wierd triadic relationship", at consultations with service users (Fieldnotes 6.1.10). Practitioners coined spatial metaphors such "corridor psychiatry" (the venue for the hurried conversation with the consultant) (Fieldnotes 10.2.10) and "desk nursing" (Phil interview) to describe these new constraints on the nature of their work as the outward gaze into the community turned inward to the computer screen.

These shifts have profound implications for the nature of practice in this reconfigured field. Social worker Ruth explained that she had chosen to work in mental health over other specialisms within her profession primarily because there had historically been more space for work with service users, but now contact time was markedly reduced (Ruth interview). Another social worker, Yvonne, described this too. She could meet with service users only monthly now instead of every two weeks (Yvonne interview). Constance (social worker) felt that being more desk-based would significantly impact on the quality of her relationships with service users, and feared becoming a “robot” rather than emotionally engaged in her work (Constance interview). Kath (CMHN) noted, “I don’t do therapeutic work anymore [...] I feel like it’s the Spanish Inquisition. I don’t have time. It’s just asking things and then I have to go” (Fieldnotes 24.3.10). She later described this approach as “the business end,” checking the user’s safety, medication compliance and mental state. She noted the dehumanising effects of time constraints, explaining that, “the more you spend time with people, the less you see them as illness and more as people” (Kath interview).

As already noted in Chapter 7, the study’s participants problematised this inquisitorial mode oriented to ‘sleep, mood and meds’ to which they felt their practice was being reduced (Fieldnotes 23.2.11). Fewer opportunities for relationship-based and therapeutic work and less contact time limited the possibilities for practitioners to develop a broader, more holistic understanding of the service user’s distress through greater depth of engagement with the individual’s meanings and experiences in the context of their family and community. This accords with Spandler and Stickley’s

(2011) observation that the constraints and pressures on practitioners in the context of neoliberal restructuring undermine the possibilities for practice to encompass the compassionate and hopeful orientation that is central to recovery approaches. As a consequence of these processes a tendency towards a more defensive and medicalised practice was generated and, as contact and support reduced, responsibility for care increasingly transferred to service users and their families. The shift from depth to surface in mental health practice (Luhrmann, 2001; Leader, 2012) ran counter to the preferred orientation of most team members and placed professional values in conflict with the managerialist organisation of the context of practice.

While 'desk-bound' practice produced reductive tendencies, other organisational processes further reinforced these. Eve pointed to the challenge of adopting a non-deficit focused approach to data collection when there is no field for the strengths of the service user on the RiO CPA form (Fieldnotes 24.3.10). Moreover, as Wallcraft (2010) has noted, the managerialist translation of concepts such as recovery into organisational procedures has undermined a service user-centred orientation. For instance, Eve explained that senior managers in the Trust and a supported housing provider had utilised the recovery model to underpin a shift away from a 'home for life' model in accommodation. Eve betrayed her irritation when commenting that she doubted whether the Trust Director responsible would wish to move home every two years as this new approach proposed. "Our values are supposed to be client-centred but that's not client-centred," she added (Fieldnotes 16.4.10). Similarly, Leslie argued that:

People have become focussed on the stars on the charts, you know, the recovery star and... the paperwork process, rather than the practical process of recovery and what exactly recovery means for different people and the individuality of working with people (Leslie interview 1, p.9)

As a result the recovery model had come to be seen by Kath as “weighted and political” (Kath interview). Moreover practitioners felt that opportunities to engage in recovery-oriented, person-centred practice with individuals and communities were diminishing as these types of work were increasingly contracted to the voluntary or third sector (Leslie interview 2). The context of this is the neoliberal purchase/provider split (Ramon, 2006; Ramon, 2007).

The tensions and contradictions perceived by practitioners in the organisation’s claims to prioritise person-centred approaches became starkly visible at a meeting at which Trust senior manager Terry initially presented the SLM proposals to the team. Terry framed the proposals in terms of the achievement of better service user outcomes and levels of satisfaction. Ruth and Kath captured the general mood of scepticism when they explained to him how hard it was to be person-centred when a target-driven requirement to enter data reduced contact with service users. Terry replied: “But the service needs to be person-centred or we won’t meet our targets” and shortly after added, “regardless of the admin, we need to prioritise care. Person-centred is the dominant philosophy” (Fieldnotes 2.2.11). His position captures a paradox: the performance indicator regime itself undermines the goal it nominally seeks to achieve. Moreover these comments exemplify a key tendency in contemporary policy and organisational frameworks that this study seeks to

illuminate. That is the de-coupling of concepts and values from the structural contexts which enable or constrain their articulation.

The organisational construction of 'person-centred' articulated by Terry has a particular character under neoliberalism and involves the recasting of the service user/survivor as an individualised consumer (Ferguson, 2007) who becomes responsible for managing their social and biological risk factors via individual lifestyle 'choices' (Petersen and Lupton, 1996). Numerous examples of this responsibilisation of users in the neoliberal stratum were given in relation to Manu and Alistair in Chapters 6 and 7. A significant effect of this is to marginalise the impact of social inequalities on health (Muntaner et al., 2000) and the relationship between mental distress and social structural factors such as race, class and gender (Rogers and Pilgrim, 2010).

However, where services consider that users are not satisfactorily managing risks to self or others, individuals are subjected to increasingly authoritarian measures and community practitioners' work becomes focused primarily on monitoring behaviour (Moncrieff, 2009b). For this reason the issue of risk has come to play a pre-eminent role in much statutory mental health practice and fundamentally shaped the interventions with Manu and Alistair. It was noted above that practitioners often felt compelled to adopt an inquisitorial mode as their contact time with service users is reduced. Roger explained that the practitioner role has now become a form of "social policing" rather than therapy and support (Roger interview 1). The primary tool of risk management is the prescription and monitoring of compliance with psychotropic

medication, and this has become a virtually ubiquitous strategy in CMHTs (Moncrieff, 2009b). As Constance (social worker) noted, “It’s all just about meds here... and risk”. She wondered aloud if there was too much emphasis on risk, clarifying that she did not mean to imply there were no risks, but expressed concern that, “we’ve become obsessed with it”. A tendency to over-emphasise risk, she argued, has the effect of dehumanising the service user, and as such further undermines the goal of person-centred services (Fieldnotes 22.1.10). The effect on practice is that “covering your back” (Kath interview), or “arse” as Roger put it (Team meeting 16.6.10), has become a primary and constant concern enacted through defensive intervention and information recording strategies, an increased focus on medication compliance and the marginalisation of positive risk-taking. Moreover CMHN Bill argued that as a consequence of greater bureaucratic burdens and less contact with service users the goal of assessing and managing risk was itself undermined, because “the best way of assessing risk is to be with people” (Bill interview).

Emblematic of the greater focus on risk management is the community treatment order (CTO). Practitioners viewed these critically or with ambivalence. Consultant James explained that he was initially opposed to this measure. Social worker Yvonne considered their overuse a form of ‘abuse’ and argued that they were being utilised to enable quicker discharge from in-patient wards in the context of funding cuts and bed reductions (Yvonne interview). However, for James, while CTOs are “all about coercion,” he also acknowledged that he had now been “socialised into them,” and suggested that their introduction merely served to formalise an already established procedure: presenting the patient with the possibility of return to hospital if they did

not comply with treatment. However he reflected that this kind of structure tended to create the conditions in which other potential approaches were marginalised. He noted that in France there was much less emphasis on legal compulsion but the suicide rate there was not higher than the UK. He argued that this de-emphasis enabled a space in which other types of intervention could be considered, for instance involving families (Fieldnotes 27.5.10). It is thus apparent that risk practices and discourses in the mental health field serve to remobilise reductive biomedical interventions to the exclusion of more holistic and person-centred approaches. Moreover, as noted earlier, the dehumanising of service users that accompanies this focus tends to reinforce 'structural stigma' (Warner, 2007).

While the greater emphasis on risk management that emerges during the neoliberal period thus remobilises the biomedical stratum, the introduction of payment by results (PbR), a crucial element of marketised reform, also seems likely to have this consequence. The development of the market in mental health via PbR, described in Chapter 3, involves 'clustering' or the allocation of mental health service users to a diagnosis-related category to determine their care pathway. In this way biomedical understandings are reinforced with diagnostic groupings forming an integral part of assessment, commissioning of services and payment for practitioner activity. While the introduction of the 'clustering' process occurred during the course of data collection for this study, the service reconfiguration to align with PbR's requirements followed my withdrawal from the field. As a result further research is required to examine the effects of SLM and the new cluster-alignment of teams on conceptualisations of mental distress.

One significant effect of the re-emergence of the biomedical stratum in the context of the neoliberal transition is a marginalisation of understandings of the impact of social factors on the development and expression of mental distress (and this interacts with the individualising tendencies of responsabilisation, noted above, that render social structural factors less visible). Roger coined the phrase “diagnosis human being” as an ironic and humorous rejection of a tendency towards biological reductionism (Fieldnotes 11.2.10). However, this is redolent of a more serious critique of the way medicalisation of mental distress emphasising ‘symptoms’, ‘disorders’ and ‘diagnosis’ screens out the role of people’s life experiences and environment in the development of various forms of distress (Boyle, 2011). Biomedical orthodoxy complements the highly individualised orientation that is dominant in a neoliberal ideology. The biomedical model holds that mental ‘illness’ is rooted in a person’s faulty biology or maladaptive thought patterns, necessitating individualised solutions such as psychotropic medication or CBT that promote adaptation to current social conditions. This model is thus particularly well suited to a marketised restructuring of mental health work and society with biomedical psychiatry and neoliberalism buttressing each other in ‘a marriage of convenience’ (Moncrieff 2009b).

These interlocking dynamics provide fertile ground for the promotion of so-called evidence-based interventions that, it is claimed, are more measurable, efficient and cost-effective such as psychotropic medications, and that remain overwhelmingly the most common treatments both within community services (Moncrieff, 2009a). Meanwhile social or psychotherapeutic approaches which are harder to measure,

quantify and cost but frequently more effective have tended to be marginalised (Tietze, 2011). An example of the latter was a discussion at a managers' meeting when participants were expressing concern about the restructuring of family therapy in the Trust and the potential loss of this service's input to CMHTs. At this point Assistant Director Derek interjected gruffly, "how do you measure outcomes with that [family therapy]? I mean in these times we have to justify that". Several managers were quick to emphasise how valued this approach was, in particular in complex cases (Fieldnotes 12.2.10). Eve's earlier comment that the Trust values only 'what is measurable' seems apposite in view of Derek's statement. Furthermore, as Ferguson (2008) has noted, the orientation to evidence-based practice while apparently ideologically neutral is in fact highly political and suited to individualised forms of practice concerned with expertise in the management of behaviour and risk that are prominent within a neoliberal context rather than those oriented to the qualitative dimensions of relationships or questions of power and oppression.

8.4 Resistance to managerialism and reductive forms of practice

However resistance to these organisational processes and reductive forms of practice was also apparent at Southville CMHT. This section will explore examples of these as they relate to micro, meso and macro levels. The structure of this section draws on the typology of progressive and radical forms of practice developed by Ferguson (2009) and Ferguson and Woodward (2009).

At the micro level, there were numerous ways in which Southville practitioners sought

to resist reductive interventions and retain a commitment to a trusting and empathic relationship-based practice (Ferguson, 2009). One example is the engagement of CMHN Leslie with a service user called Jonny. The work sought to utilise tools associated with narrative therapy, such as the tree of life, to assist with Jonny's identified goals of strengthening family ties. Such approaches were highly valued by this service user and appeared to contribute to stability in terms of his mental health. While maintaining this level of input with a service user who was not 'in crisis' presented particular challenges in view of the pressures of his considerable caseload under conditions of strenuous welfarism, Leslie described his determination to continue to engage in such time-intensive forms of intervention (Fieldnotes 15.12.09).

Another micro-level form of resistance to managerialism involved work to utilize the discretionary spaces remaining in order to promote socially just forms of intervention (Ferguson, 2009). Eve's intervention with a service user called Paul who was facing the distress of being required to move from his long-term residence was an example of this. Rituals and routine were important for Paul and so, although it was not possible to negotiate for him to remain in this flat, Eve engaged in intensive advocacy work with the local housing department over a number of months to ensure that Paul was not allocated unsuitable accommodation and was able to exercise choice in the location of his new home (Eve interview 1). Another example of localized resistance is the rejection of the offers from pharmaceutical company representatives to fund lunches and provide information and complementary resources at Southville CMHT. Eve said there was consensus between her and James on this driven by a desire to keep corporate interests at arm's length (Fieldnotes, 3.2.11). These practices

constitute what White (2009) has called 'quiet challenges' to managerial power.

It was noted above that service reconfigurations tended to undermine more egalitarian and democratic forms of practitioner-user/carer engagement forms of intervention, imposing individualizing and sometimes restrictive forms of practice. However, the bi-monthly 'Mental Health Matters' group co-facilitated by Eve, Leslie, other Trust workers and service user colleagues sought to create spaces accessible to wider communities, thus challenging these constraints on provision and the restrictions of eligibility criteria. These sessions had an egalitarian ethos, avoiding overt demarcation of user and practitioner participants. Leslie also noted the influence on his practice of 'campaigning organisations, like the Hearing Voices network and the Campaign to Abolish the Schizophrenia Label... the Soteria Network and so on'. He argued that these reframed service user-practitioner power relationships and had succeeded in 'changing perspectives' in the field to challenge "the medical model... [and its] one size fits all" approach (Leslie interview 1).

However in addition to these micro level forms of resistance, more collective and explicitly political practices oriented to community and trade union structures (meso level) were also visible. The first example is advocacy by social worker Farooq of the need for practitioners to develop cultural understanding and spend time alongside families in a community work role in particular with the British-Pakistani community resident in the local area. Since joining the team Farooq had sought to actively engage in this role as far as possible but expressed concern about the lack of support for this work amongst senior management within the Trust. He added that

the individualised nature of practice models constituted a barrier to this approach (Farooq interview).

Another example at the meso level is the development of links across the Unison health and social services branches instigated by CMHN Roger and social work trade union representative Alan in order to adopt a more integrated campaigning orientation. One initiative was a proposed joint statement and petition, drafted by social workers that sought to mobilise staff from across the Trust against service cuts and increased workloads (Fieldnotes 18.6.11). The possibility of meso level alliances across occupational boundaries, and with service users, was also apparent in a lobby against cuts within the Trust organized by local anti-austerity activists and attended by service users, and health and social workers (Fieldnotes 4.8.11).

Some practitioners were also involved in wider social movements (Ferguson, 2009). For instance CMHN Bill invited me to accompany him to a protest against NHS privatisation, where we encountered six practitioners from Northville CMHT, social workers, nurses and an OT, who had travelled to the event together (Fieldnotes 17.5.11). These activities stimulated debate in the team around the role of macro level neoliberal processes in health policy, but also highlighted potentials for horizontal solidarity at the meso level that undermine differentiated notions of occupational identity.

In summary this section has identified forms of resistance to practice modes that orient to biomedical reductionism and defensive risk management. These

developments encompass processes that operate at macro and meso as well as micro levels. This reinforces the utility of a reconstruction of the pentimento that incorporates a conception of levels of scale as well as historical strata. Moreover this discussion indicates that these ontological levels should be understood not as static but as both emergent and dynamic. These provide a context that facilitates greater understanding both of the constraints on the activity of practitioners and service users but also the structural processes that enable particular forms of individual and collective agency. The latter have the potential to constitute ideological and practical challenges to current neoliberal reconfigurations.

8.5 Summary

This chapter has provided an overview of some of the effects of the neoliberal transition experienced by mental health practitioners at Southville CMHT. I have argued in the chapter (and the thesis more broadly) that three interacting dynamics characterise this process. At the centre is the marketised reconfiguration of care and support visible in the purchaser provider split, neoliberal managerial target regimes and further expanded through the payment by results SLM reconfigurations. In this context responsibility is increasingly privatised to the service user and their carers. However where it is considered that the service user is not satisfactorily managing risk coercive forms of intervention are legitimised. The resources available for community mental health work are increasingly allocated on the basis of perceived risk rather than service users' needs. The neoliberal transition thus tends to marginalise holistic forms of practice and constrain the possibilities for relationships

in CMHT work to develop the longevity and depth to enable greater understanding and reach into the wider arena of the family and community. These temporal and spatial restrictions are reflected in metaphors such as 'corridor psychiatry' and 'desk nursing' that evoke the shrinking boundaries of the work, as practitioners are tied to their desks by bureaucratic functions. Even within an individual casework mode greater constraints on time mean that work eschews depth and operates at the surface of checking mental state and compliance, 'meds, mood and sleep', while the promotion of short-term intervention over long-term relationships hampers engagement with the meanings attributed by the user to their experience and with their sense of identity. Practitioners' concerns around this are consistent with Leader's (2012) comment that mental health services now resemble 'a garage to rehabilitate' service users then return them to their families, rather than providing a space to listen and understand their distress.

However the chapter has also identified forms of resistance to these processes that operate at macro, meso and micro levels. This demonstrates the utility of the synchronic as well as diachronic (spatio-temporal) reconstruction of the pentimento to develop a dynamic conception of knowledge and practices. Activities at these levels span a continuum from individual relationship-based practice and egalitarian group and community approaches to collective forms of campaigning and trade union activity. Moreover these forms of resistance suggest the potential for the activity of practitioners and service users not only to structurally reproduce the service context but also to engage in its structural transformation.

In the next chapter the data and themes presented here and in case study Chapters 6 and 7 will be discussed in closer relation to the analytic framework of the pentimento in order to demonstrate how they were utilised to inform its reconstruction.

9. THEORETICAL SYNTHESIS

9.0 Introduction

In this chapter I will discuss and develop some of the analytical strands that emerge from the previous three chapters of the thesis and examine how these have been utilised to develop and extend the overarching theoretical framework of the pentimento as a laminated system.

The structure of this chapter will be as follows. It will begin with a brief reiteration of the reconfigured pentimento first presented earlier in Chapter 4. The second section will present an overview of the key theoretical implications of the understandings of Manu's mental health needs discussed in Chapter 6 and link these to the pentimento strata. Similarly, in the following section a consideration of analytical themes from Chapter 7 concerning Alistair will be presented and linked to the proposed pentimento layers. The fourth section will draw on these case studies and the data presented in Chapter 8 to argue that an understanding of the mental health team as a laminated system requires the pentimento to be supplemented with a conception of levels of scale, from micro to macro. The fifth section will draw these strands together, providing a restatement of the arguments for the necessity of a historical and epistemological reconstruction of the pentimento in light of the data and analysis presented in Chapters 6, 7 and 8. In the final section key themes from this chapter will be summarised.

9.1 The strata of the reconstructed pentimento

In Chapter 4 above, a reconstructed pentimento was proposed, constituted by four key historical ‘moments’ in the development of mental health services in England.

These strata are:

- (i) The custodial system of the asylum;
- (ii) The biomedical treatment system of the hospital;
- (iii) Community care within the Keynesian welfare state;
- (iv) Neoliberal reconfiguration of services.

It was argued that these conjunctural welfare settlements are not neatly demarcated from each other but in a process of temporal emergence, where newer spatial layers overlap with and partially supersede those of the earlier period. As such mental health services should be understood as differentially sedimented structural institutions. The dominant institutional forms and associated concepts and practices of mental health service provision within each stratum provide a structural context for the embodied agency (‘gestures’) enacted by practitioners, service users and carers.

While the pentimento aids understanding of the diachronic effects of spatio-temporal emergence, further development is required to conceptualise the synchronic interaction of different ontological levels of scale. It has therefore been argued that three levels of scale should be integrated with the pentimento. These are:

- (i) Macro level: political economy shaping the particular form of the welfare state, e.g. neoliberalism or Keynesianism;
- (ii) Meso level: occupational and organisational processes; and
- (iii) Micro level: individual and situational.

In summary the reconstructed pentimento, incorporating both diachronic and synchronic dimensions, offers a means to provide a dynamic, contextually-situated understanding of models of mental distress that overcomes the limitations of static, reified conceptualisations of knowledge typically encountered in the mental health field. The utility of this model will now be demonstrated via its application to the data from the study.

9.2 Manu: relating analytical themes to the strata

In Chapter 6 a 23-year old black service user named Manu was introduced along with his community mental health nurse/care co-ordinator Abbie, and consultant psychiatrist Dr James Bryant. Manu was, at the time, an inpatient at the Middletown Centre Mental Health Unit, and discussions revolved around the breakdown of his community placement at Britchcombe Road hostel and the possibility of his transfer to a forensic unit. This section will set out the ideological positions underpinning the perspectives of these participants as they are articulated in relation to two key dimensions: conceptions of causation of mental illness/distress and appropriate

interventions, and then link these to the ideological strata or 'layers' of the pentimento presented in Chapter Four.

While James is non-committal on aetiology he articulates what he calls a 'biological construct' for understanding Manu's condition: which he defined as schizophrenia. This appears to draw on stress-vulnerability models (Zubin and Spring, 1977) where environmental factors constitute a trigger in those who are biologically predisposed to the condition. One dimension of this construct is described in the first ward round where Manu's behaviour is explained in terms of reduced frontal lobe activity. An intervention strategy involving psychotropic medication is thus advocated. A further biological factor identified by James was Manu's use of substances such as cannabis and crack cocaine that were likely to trigger a re-emergence of his psychotic experiences. Here James' perspective is positioned within the biomedical stratum, however while the stress-vulnerability framework extends the locus of medical discourse into the service user's environment evoking the systemic community care stratum, its subsidiary role suggests the incorporation of the social by the medical (Barrett, 1996).

The community care layer is also suggested by the 'biopsychosocial' approach claimed by James. This integrates an acceptance of the ontological validity of conditions such as schizophrenia with an argument for their expression as mediated and shaped in particular ways by a process of narrative construction within institutional and social fields. This systemic dimension is articulated when James reflects on the labelling of Manu by hostel staff generating a negative feedback loop

that undermined the possibility of therapeutic progress and recovery. His utilisation of this ecological framework also enables him to generate insights into the tensions producing 'failures' of service intervention with Manu within this organisational system. This will now be discussed in greater detail.

The key intervention proposed by James was a strategy of 'institutionalisation' as a means to try and prevent a cyclical process of discharge, subsequent problematic drug use, 'relapse' and readmission. This strategy of 'boundaries' was to be implemented by reducing Manu's access to substances via admission to the locked ward environment, making visible the stratum of custodialism.

However this bounded approach formed only one part of a broader strategy that might be characterised as operant conditioning within a behaviourist paradigm. This involved 'encouragement' through positive reinforcement – substituting the stimulation sought through substances with activities deemed to be rewarding (but also therapeutic) - on the one hand, and 'consequences' via the withdrawal of valued outcomes such as moves towards more independent accommodation in the event of behavioural breaches on the other. James also recommended psychological interventions to address and manage the cognitive impacts of his condition. This incorporation of the psychological as part of a broader systemic biopsychosocial strategy evokes the stratum of community care.

The aim of his approach, James explained, was to reduce risk to Manu by creating a 'protective bubble' that shielded him from the environmental risks of a violent drug

subculture and the cognitive deterioration characteristic of schizophrenia. While this may also appear to re-articulate the custodial stratum, here a newer discourse of risk is also apparent that constructs his intervention in terms of managing potential biological risks *to* Manu as well as the danger presented *by* him. This newer conception is linked to the dimensions of risk and responsabilisation within the neoliberal stratum.

Overall, James' conceptualisation of Manu's mental health needs incorporates a number of ideological strands that represent forms of knowledge emerging at different stages in the development of professional psychiatry. These include the historic custodial role in relation to those deemed mentally ill, the biomedical model, and the later biopsychosocial reframing of this to include the impact of the wider environment emergent with the community care system. The latter stratum is also apparent in James' theoretical identification with psychological approaches. In the interview he emphasised the role of psychiatrist Aaron Beck in the development of cognitive therapy, and as such seeks to incorporate this field within psychiatry. Newer risk discourses emerging in the context of neoliberalism are also visible. However powerful tensions between these ideological strata are apparent because they implicate different types of practice or 'gesture'. These will now be discussed in more depth.

While Manu is initially placed in the community hostel, James summarised his strategy for the work as 'medication, boundaries and encouragement'. However, the strategy of encouragement via positive reinforcement reaches crisis point when a

Britchcombe Road worker explains that Manu has not been taking medication.

James immediately acknowledges that this represents grounds for swift recall to the ward as medication forms the key technology underpinning risk minimisation in the community. At the subsequent ward round hostel staff articulate further risk concerns, that Manu is hearing voices instructing him to kill people, the discovery of a knife in his room and his cannabis and alcohol use. Noting to Abbie that “you can’t work with...threats and knives”, James reluctantly accepts the need for Manu’s readmission.

When Manu has returned to the ward, James noted that a combination of three ‘parallel’ strands in his approach to work with this service user: institutionalisation (risk minimisation through custodialism), therapy and medication, did not produce a successful outcome because of a significant tension between two of these. James perceived this ‘failure’, over which he agonised, to have been produced by the custodial strategy creating dependency that in turn undermined the goal of the therapeutic work that sought to inculcate skills for supported living in the community. James’ concern can therefore be reconstructed as a contradiction emerging between the gesture of institutionalisation, positioned ideologically within the related strata of custodialism and risk, on the one hand and that of community placement located within the community care layer on the other.

However, while this illustrates strategic movement by James between the community and custodial strata in response to the re-emergence of risk concerns within this domain, an alternative perspective is articulated by Manu himself. He rejects the

institutionalisation strategy arguing he needs to make individual choices around managing drug use, and take personal responsibility for seeking employment. This evokes responsibilisation, and is embedded within the neoliberal stratum.

In response, James explains to Manu that he believes this service user will need to manage the responsibility of moving towards independent living more gradually and balance this with the protection provided by the hospital. Here James is advocating the 'sick role' position associated with a community care orientation insofar as this strategy is underpinned by Keynesian welfare provision. The four key dimensions of Talcott Parson's notion of the sick role are the legitimisation by a physician of exemption from typical societal responsibilities, the justification of the direction of care-giving practices towards the person concerned in view of their condition, and with this the obligation on the part of the person so defined to seek appropriate help to enable recovery and to cooperate with the doctor in this process of getting well (Clare, 1997).

The question of the extent to which responsibility for actions should reside solely with the individual experiencing mental distress has long been a vexed one for mental health professionals. The latter have tended to adopt two contrasting positions on the question (Clare, 1997). Those advocating the sick role have tended to look to an organic model to support the position that the person should not be held responsible while a moral model has been articulated by those who believe the individual should be held primarily accountable. In exploring this dichotomy, Ahn et al. (2009) argue that practitioners' treatment decisions and recommendations are related to their

beliefs about the relative importance of biology or environment in the development of particular forms of mental distress, and that the tension between illness and personality is grounded in a deeper cognitive structure of mind-brain dualism. Miresco and Kirmayer (2006) propose that this underpins differential attributions of responsibility and blameworthiness made by practitioners according to whether personal agency is attributed to actions (personality) or not (illness).

Barrett (1996, p176) concurs with this, and argues that contra the textbook recommendation of non-judgemental practice that the moral evaluation of patients is a central part of treatment: therapeutic work involves effecting progress from a case of schizophrenia to a person regaining control of their illness and thereby responsibility for their actions. However the 'chronic schizophrenic' is an anomalous category of person constituted in the interstices between voluntaristic and deterministic constructs, partaking of elements from both the normal ('good' patient) and abnormal ('bad' patient) trajectories.

Such tensions are apparent in the differing orientations of James and Abbie. While James advocates the sick role, Abbie deploys the category of 'personality' as a primary explanatory framework for Manu's actions and to emphasise his responsibility for them. Brown and Baker (2012) have described the increased use of the 'personality' category in mental health practice as representing an extension of neoliberal responsibilisation into the practice arena. This contrasts with James who develops a notion of Manu's personality as 'underdeveloped' to reduce the degree to which responsibility should be attributed to him and legitimise the sick role.

Abbie's orientation could be seen as a consequence of applying a moral model, drawn from psychodynamic theory. At the first ward round she appears more sympathetic to the concerns of the hostel staff, describing Manu's anger which was communicated to her non-verbally when they had met shortly before. Later, at the team meeting this is articulated in her description of this service user as 'disturbed', 'paranoid and dangerous'.

However, concerned that this forensic trajectory might be viewed as draconian, Abbie reframes this as a necessary form of 'holding' in the context of Manu's regressed behaviour. This apparent evocation of Bion's notion of containment (Bion, 1963) seems to suggest implicit elements of a psychodynamic approach, even though Abbie eschews the notion that a more overtly theoretical stance informs her work. Her advocacy of the use of self and 'listening to feelings', and her training in an intense groupwork setting seem to lend support to this and implicate the therapeutic dimension of the community care stratum. This is also apparent in the attempts to engage Manu and his relatives in family therapy. In this sense Abbie's theoretical perspective may be seen to be shaped by systemic and psychodynamic therapeutic orientations which form a significant component of the professional knowledge base of mental health nursing (Peplau, 1951).

Abbie's concern with risk is articulated again in the interview context. When asked to describe her understanding of Manu's mental health issues, Abbie utilises the diagnostic category of anti-social personality disorder, and the administrative

category of 'forensic', alongside the term psychosis. Such definitions tend to be associated with a conception of 'dangerousness' and as such within the risk dimension of the neoliberal stratum, but also remobilise the earlier custodial layer. Nonetheless these diagnostic and administrative concepts are mobilised strategically to achieve what is for her the 'correct' gesture in this situation, Manu's placement within a more secure setting.

In contrast, as noted above, James articulates his perspective in terms of the sick role. However, during the latter stages of the interview, he articulates this conception in greater detail and relates this to contemporary socio-political transformations:

I hate it when patients are called customers, it just seems a lie as if they have the choice and the rights of a customer, that they're consuming something and it also takes away their, their rights within the sick role [...] by calling somebody a customer you somehow cheat them out of their sick role. You know, I think patients have rights that customers don't and I don't want my patients to be seen as customers. (James interview 1, Pt.2, p.22)

James links the undermining of the sick role with the development of a neoliberal consumerist orientation towards service users. He goes on to clarify this:

It justifies not providing care. Look it's, it's, it's complex you know, because on the one hand it's as, as, a service ideology and structure which encourages people to be, towards autonomy is good, autonomy is good, patient autonomy is good. But along a spectrum if that's taken too far and the patient then is deemed to have total responsibility for their behaviour and, so it's a kind of Thomas Szasz model, so if they commit a crime they should go to prison you know, if they swear at a hostel worker they should be evicted, then I think that's highly problematic and then they're not being allowed their sick role. So not only, you know, could it be argued that they've been unfortunate enough to have this condition not only in general does society shit on them through stigma and through exclusion, now they're not allowed the care which would have been the compensation from society, the meagre compensation for that. They're called customers and they're expected to control themselves when by definition part of having a mental illness is sometimes you lose control, not always, but it's necessary to have a dynamic changing idea of when

somebody can and when they can't be autonomous... And some people may say that's paternalistic but I think it's realistic. (James interview 1, Pt.2, p.23)

Here James links the erosion of the sick role with the emergence of neoliberalism enacted through the extension of the market and consumerism into the mental health service domain. While he welcomes the goal of greater service user autonomy he also qualifies this. Rejecting the charge of paternalism frequently made by advocates of consumerism against its critics, he notes that reconfiguration involving the devolution of 'total responsibility' to the user in accordance with the tenets of right-wing libertarianism promoted by Szasz (Sedgwick, 1982) renders such individuals much more vulnerable to the withdrawal of care and support services if they 'lose control'.

However, while the ideological stances Abbie and James adopt contrast (which links at least in part to differing occupational cultures and professional knowledge bases), the gestures they recommend nonetheless converge, which is related to the organisational context of action. In this regard, Parker et al. (1995, p.16) are right to note that mental health services are institutional power structures which operate regardless of the intentions of individual practitioners within them.

Institutional processes are again apparent when impacting on Abbie's definition of Manu's mental health needs as forensic. Abbie's interpretive strategy, utilising her feelings, has been reshaped by this institutional context of practice. This becomes particularly visible when Abbie describes the enormous pressure placed on her as Manu's care co-ordinator to find suitable 'move-on' accommodation within

organisationally defined time frames. The 'desperation' and 'panic' emerges not primarily from Manu and his family but another part of the NHS Trust and is linked to organisational performance indicators. This is an indicator of a process of neoliberal managerialism whereby services are reconfigured in accordance with market imperatives through the imposition of bureaucratic procedures and targets noted in Chapter 3. The discursive resources upon which Abbie draws to resolve this dilemma are also reconfigured by managerialism insofar as she uses the administrative category of 'forensic' as her primary definition of Manu's need rather than a biomedical diagnosis (although she does also utilise the latter in a subsidiary fashion).

This notion of 'forensic' articulated by Abbie may be seen as a new hybrid conception emergent from the integration of biomedical and administrative categories. This is also apparent in the Mental Health Clustering Tool (MHCT) recently introduced to the CMHT as part of the new market-oriented payment by results (PbR) system (noted in Chapter 3). The reshaping of interventions and conceptualisations via marketisation and managerialism is associated with the neoliberal stratum introduced above.

Another effect of this neoliberal layer can be detected in the tension described earlier between James and Britchcombe Road staff in the ward round meetings.

Consequently James expresses concern about the impact on Manu of the difference in skill and training levels between NHS ward and community staff and those working in the hostel. The provision of services at Britchcombe Road is by a third sector organisation, whilst Southville CMHT and Upton Ward remain within the public sector NHS. This is a result of the privatisation and outsourcing of community residential

services heralded in the NHS and Community Care Act 1990, legislation that promoted a 'mixed economy of welfare' in which a range of providers operate within a healthcare market (Rogers and Pilgrim, 2001).

A third articulation of the neoliberal stratum is apparent in Manu's orientation to individual responsibility and 'responsibilisation' (Garland, 1996). The latter concept is also a useful prism through which to understand the changes described by James above, involving concurrent 'soft' and 'tough' strategies. The soft dimension involves the fostering of Manu's responsibility for managing his 'illness' via compliance with medication and treatment, while the tough entails the implementation of draconian risk surveillance measures under the Mental Health Act (MHA) 2007 (Carpenter, 2009). However, one important dynamic within the 'tough' dimension - the disproportionate level of coercion experienced by black service users within mental health services (McGovern and Cope, 1987) (cited in Rogers and Pilgrim, 2010) and broader issues around the construction of race and ethnicity in this domain (Fernando, 2002) were not articulated.

The continuum James describes running from the institutional containment of risk at one extreme to the freedom and responsibility of individual self-care at the other indicates a newer emergent stratum associated with the contemporary neoliberal restructuring of services and society. Its key dimensions are the devolution of responsibility for self-management to the individual in an increasingly marketised service context alongside the legitimisation of restrictive interventions with service users who fail to embrace or adapt to these new requirements. This layer operates in

tension with the community care layer evoked in James' conception of the sick role. To summarise: user involvement, risk and marketisation constitute the three inter-related dimensions of a new 'neoliberal' stratum.

9.3 Alistair: relating analytical themes to the strata

We now return to discussion of Alistair, first encountered in Chapter 7. This service user is a 44-year old white man who works in a senior management role in the insurance industry and has separated from his wife Felicity, who remains his carer. Alistair was allocated a social worker Filipe as care co-ordinator, and has the same consultant psychiatrist as Manu, Dr James Bryant. Following admissions to the Middletown Centre Mental Health Unit, Alistair had now returned to work and re-established regular contact with his wife and family whilst they work on rebuilding relationships with the support of practitioners from the community team. However concerns remained regarding the future re-emergence of ideas of suicide. As above with Manu, this section will now recap the implicitly or explicitly articulated ideological positions of key participants, and then consider these in light of the layers or strata of the pentimento.

In chapter 7, a number of key themes emerged from James' conceptualisation of Alistair's mental health needs during the research interview. He defined these needs in diagnostic terms as 'bipolar affective disorder' though in an unusual form due to late onset. James' mode of reasoning is again consistent with the stress-vulnerability hypothesis, involving a stance on aetiology that incorporates both biological (genetic

inheritance) and environmental (familial relationship) factors. This vulnerability is triggered by the addition of work stress/dissonance, and lifestyle (status-income) pressures, and the expression of his illness is mediated by the development of forms of dependency within his current familial environment. James' correspondence with Alistair's GP provides bio-medical reasoning for the diagnosis and adjustments to his medication. Once again, James' conceptualisation is located within the biomedical stratum, with the stress-vulnerability model extending this to incorporate ecological dimensions identified with the systemic community care stratum.

The ecological synthesis, framed as 'biopsychosocial' is reflected in the roles adopted within a multi-professional service context where medical, social work and psychology input is effectively integrated to address these different dimensions of Alistair's needs. In terms of the latter two, James reframes this service user's needs in more explicitly cognitive terms to provide a rationale for CBT, and constructs social and community support to Alistair and Felicity in terms of relapse prevention reflecting incorporation of the psychological within an overarching integrative approach that reflects the community care stratum.

However, the type of intervention strategies or 'gestures' selected depend, James argues, on whether Alistair is at the acute or stable phase of his illness. The acute stage is characterised by increased suicide risk and as such the most appropriate approach involves the use of medication to lower mood and consideration of admission (the biomedical and custodial layers). During the stable phase, self-management supported by psychoeducation and advance directives is increasingly

recommended in line with responsabilisation strategies consistent with a neoliberal orientation. The significance of this development is highlighted in later communications following Alistair's relapse and admission. Here James identifies Alistair's 'learning experience': an understanding that this user's illicit decision to reduce his Lithium dose was a central factor leading to relapse and the likelihood of more effective self-management in future that will arise from his new insight.

While initially social worker/care co-ordinator Filipe's construction of Alistair's mental health issues forms a stark contrast with that of James, in practice parallels also emerge. Filipe explicitly rejects genetic and biological aetiology and what he considers reductive diagnostic categories, advocating instead environmental causation linked to lifestyle (status) and life course (midlife crisis) factors. However he later moderates his position somewhat, though he continues to problematise medical labelling processes. Filipe's preferred modes of intervention with Alistair are practical support and talking therapy, while he is critical of biomedical interventions including the 'cocktail of medications' prescribed. His chosen therapeutic approaches include humanistic and cognitive behavioural interventions, and practical support focusing on housing and employment rights. As such Filipe is unequivocally positioned within the therapeutic-systemic community care stratum.

However Filipe's critical orientation towards a biomedical stance shifts noticeably when concerns about Alistair's suicide risk increase (in an apparent parallel with the acute phase described by James). At this stage Filipe appropriates a more diagnostic vocabulary and shifts to a more favourable stance towards medicalised interventions

alongside other forms of social and psychological support. In this respect his discourse is repositioned within the risk dimension of the neoliberal stratum, where biomedical conceptions are evoked as a suitable technology for risk management.

Alistair's understanding of his own mental health needs will now be summarised. His perspective is in accord with that of James in certain respects. He agrees with both the diagnosis and the biomedical conceptualisation of bipolar disorder as a 'real disease'. His experiences match those described in a range of medical texts and other resources he has consulted, and he concurs with the assertion of a genetic dimension adding in support that his grandfather may have had the condition but been misdiagnosed with depression. This is an unambiguous articulation of the biomedical stratum.

However, Alistair explained that this position was not automatic. He was initially resistant to the diagnosis because of the perceived severity of the condition, in particular because of the impression that this may impact on his ability to continue working. His experience though was that he was not labelled by others as he had feared. Alistair was also initially ambivalent in relation to medication in particular the amount he was required to take. Alistair's motivation to engage in self-education around biomedical knowledge and psycho-education following his previous reduction and relapse enabled him to accept the rationale for this, as well as adjust to the lack of negotiation around his diagnosis. However psychotropic medication is supplemented by cognitive therapies such as CBT and mindfulness. These are, for Alistair, the most effective forms of intervention. This view is consistent with his

strong identification with self-help and personal efficacy strategies. This positions Alistair within the user involvement-consumer dimension of the neoliberal stratum. Another aspect of this neoliberal layer articulated by Alistair is his recognition of the greater bureaucratic burden carried by Filipe compared to the other members of his team. This involves the organisation of care and extensive 'form filling', particularly in relation to risk, and is related to the marketisation of services.

Alistair is broadly satisfied with the high level of service input he receives, and the operation of his multi-professional team, who he considers to hold similar perspectives on his condition. This contrasts markedly with his wife and carer Felicity, who finds the wide range of perspectives within the service and lack of 'clear answers' frustrating. She rejects the midlife crisis (developmental) argument and only partially accepts the role of environmental stress factors. However, while she finds a biological view of 'chemical imbalances' more convincing, she considers there to be no 'clear causes' of mental distress, unlike Alistair who holds a relatively definitive and unambiguous view of his condition.

Felicity decided to manage this indeterminacy by choosing to identify with James' biochemical perspective because his worldview, for her, has the greatest clarity and most closely matches her own. A key aspect of this decision was her perception of the effectiveness of psychotropic medication interventions associated with this perspective, and as such medication efficacy is seen as key in underpinning biochemical hypotheses (Healy, 2002). Felicity's ideological positioning is thus broadly within the biomedical stratum.

While Felicity passionately supports intervention with medication she is more ambivalent about talking therapy. However she strongly advocates a systemic orientation that looks at the 'bigger picture' in particular through the provision of support to the whole family. In this respect she found Filipe's approach more broadly inclusive and less individual-patient-oriented than that of James, and as such is located within the systemic community care layer.

Like Alistair, Felicity engaged in extensive reading to try and better understand her husband's condition and the operation of interprofessional services. Moreover, she expressed concern about the frequent devolution of decision-making and responsibility from services to the carer. She developed the confidence to assert her own judgement, and also utilised the opportunity to increase her knowledge. However this tended to involve the transmission of biomedical knowledge from professional to carer and user. This positions Felicity, like Alistair, as a 'responsibilised' consumer within the neoliberal stratum, though she problematises this more actively than her husband.

The competing perspectives which caused Felicity so much frustration, and the oscillations in Filipe's stance might be understood in the context of longstanding interprofessional tensions within CMHTs. However these are being reshaped by managerialist reform at the organisational level. The laminated system of scale outlined in Chapter 4 enables the development of a more sophisticated understanding of ontological stratification within the strata of the pentimento, in

particular the ways in which the interaction of these occupational and organisational processes at the meso level are shaped by broader socio-economic and political conditions at the macro level. The next section will enable further examination of the explanatory potential of the laminated system of scale as an analytical supplement to the pentimento.

9.4 Relating analytical themes to levels of scale

The previous section has demonstrated the ways in which data concerning the engagement of two service users, Manu and Alistair, with a number of mental health practitioners has been utilised to effect a reconstruction of the conceptual framework of the pentimento. However it has been argued in Chapter 4 that while this notion of sedimented knowledge is an important it is not a sufficient requirement for the explanation of stasis and change in this setting because such systems are differentiated not only spatio-temporally but also in terms of levels of scale. Particular forms of social organisation (such as professional ideologies and organisational forms) are reproduced and occasionally transformed by the situated activity of individual and collective agents, whilst they are also emergent from but limited by the broader social structural context and the particular dominant form of conjunctural welfare settlement within which they are located. The interaction of these different ontological levels is usefully conceptualised with the aid of the laminated system of scale as an analytical tool. This section will begin by providing a review of this framework. It will then utilise data from the two case studies and other stages of the fieldwork to argue that conceptualisations of mental distress in the field are impacted

by causal mechanisms at various emergent levels of scale from micro to macro. It will conclude that the laminated system of scale provides a necessary supplement to the pentimento.

As noted above, the three levels of scale proposed are: (i) macro: broader historically contingent political-economic systems shaping conjunctural welfare settlements, e.g. neoliberalism or Keynesianism; (ii) meso: processes, relations and cultures within occupational groups and institutional/organisational settings; and (iii) micro: local situational contexts and the embodied agency and biography of individuals. The utility of this framework as an analytic aid to understanding processes in the field will now be demonstrated through its application to examples from chapters 6-8.

The first is James' advocacy of the sick role in relation to Manu and this practitioner's concern that a shift towards neoliberal consumerism in mental health services will undermine the availability of this response to mental distress. The sick role, in the form articulated here, presupposes a particular type of welfare regime at the macro level. The Keynesian welfare state in the UK facilitated the provision of universal healthcare free at the point of use and extended forms of financial assistance as income replacement. This approach has the consequence of enabling support planning for Manu that is not primarily dependent on the ability of this service user and his family to fund his care package and legitimises his withdrawal from work-related activity. More recent market reforms in the field of health and social policy, while not completely superseding this model, have challenged universalist notions of welfare. A neoliberal 'active' welfare regime has emerged characterised by sanctions

to enforce reintegration into the labour market, the stigmatisation of the sick role, extended forms of conditionality and welfare budget retrenchment (Jessop, 1999). These developments at the macro level shape new roles at the meso level. James describes a reconstruction of the dominant form of practice relationship with doctor-patient reconstituted as provider-consumer. He considers the notion of customer problematic insofar as it reduces users' access to care and marginalises rights discourse. At the micro level the effect is to interpolate new modes of interaction. James seeks to engage Manu in a form of negotiation to win this service user's assent to the psychiatrist's preferred strategy, while Manu frames his own role in terms of dominant neoliberal discourses of work and individual responsibility. However there is a tension here with custodialism, the institutional legacy of a more archaic welfare system that provides a coercive background to their discussion.

The second example demonstrates the effects of the constitution of the meso level by organisational as well as occupational processes. This is apparent in both case studies, with tensions between Abbie and James over the appropriate form of intervention with Manu, and between Filipe and James in their understanding of the nature of Alistair's mental distress. To explore this it is necessary to place this in the context of the policy framework that emerged with the macro-level Keynesian community care system and that heralded new forms of community support characterised by multi-professional intervention. As Messinger (2006) has noted, and Colombo et al. (2003) imply, the differences between the various occupational groups' conceptions of mental distress and care practices consequently delivered are rooted in divergent ideological and epistemological positions. Tensions between

practitioners frequently erupt as they negotiate this meso level context and, because differences tend to follow an occupational contour, interprofessional conflict emerges (as described in Chapters 3 and 4).

However the contemporary field of professional practice is being reshaped by the neoliberalism at the macro level. This is accompanied at the meso level by the growth of genericism, orientation to organisational performance indicators and the emergence of standardised care pathways. One particularly prominent feature of this shift in statutory mental health services is defensive risk management. Abbie's definition of Manu's needs as 'forensic' provides an example of the way in which occupational conceptions of need are being reframed by managerialism. These organisational level managerial reforms in turn reshape inter-professional relationships. As a result there is a tension, on the one hand, between diverse professional cultures rooted in differing forms of occupational socialisation/ideology and, on the other, the standardisation and convergence of organisational requirements in a context of ever closer partnership working. This leads the different practitioner groups to engage in increasingly generic practices at the micro situational level. For instance, while the question of the placement of Manu taxes both James and Abbie, it does not result in a significantly different gesture on each of their parts. Both accept the forensic pathway though James agonises over this decision in contrast with Abbie who advocates this as a positive step (implying differences of value orientation at the individual level). This suggests that the tacit knowledge produced by the field, their knowledge of 'how the system works' in such a situation, is one in which Manu's placement in forensic is seen as an inevitable next step.

Similarly, in relation to Alistair, the different stances articulated by James and Filipe during the 'stable' phase are consistent with their respective occupational epistemologies. However the tensions and differences present here do not constitute an obstacle to the subsequent convergence in their recommendations when risk concerns are articulated during the 'acute' stage. At this point managerialist expectations of defensive risk control at the meso level, emergent from the broader neoliberal context, result in the suppression of occupational and ethical differences and the production of an uneasy consensus.

However this reconfigured organisational terrain characterised by intensified inter-professional integration produces contradictory responses. At managerial grades, consultant psychiatrist James and team manager Eve, a CMHN, articulated perceptions that psychologists as an occupational group, unlike their own professions, were succeeding in strengthening their position within this more integrated domain. James argues that the intellectual dynamism of psychology is underpinning a challenge to psychiatry's position within the mental health field, indicating issues of professional dominance and social closure. He links this to a broader decline in the status and intellectual health of the psychiatric profession.

At frontline practitioner level a different picture emerged. Increasingly practitioners within the Southville team seemed to acknowledge potential horizontal solidarities. An example was an article informally circulated via email amongst social workers, nurses and the occupational therapist. It was forwarded to me by social worker

Constance who implored me to read it as Phil, a nurse, and others discussed its contents enthusiastically. The article was authored by an anonymous social worker³³ and written in an eloquent and biting satirical manner. It argued that the interdisciplinary power struggle, often characterised by tensions around social and medical models, is now submerged beneath a more important battle against a 'crude business ethic' in NHS mental health services. As a result,

[T]he power relations within the team [between doctors and other practitioners] are not as important as the power relations between clinical staff and management. For this reason it is imperative we create an alliance of identities [...] a joint radical stance across the professions.

The kernel of the sort of alliance enjoined on practitioners by the article was apparent in the lobby against Trust proposals attended by social workers, nurses and service users described in the last chapter.

Later James moved closer to this second position when he reflected on these processes and the tensions and contradictions created by them. Having earlier articulated concerns about the challenge to the pre-eminence of psychiatry posed by psychology, he then sought to distance himself from these comments, describing them as 'tribalistic'. He offered an alternative reading, arguing that the horizontal divisions between occupational groupings exacerbated by professional defensiveness in a context of austerity and cuts are better understood as an expression of vertical socio-economic power differentials. James is self-critical, noting that he had constructed the relationship:

³³ The fact that the author chose to conceal their identity is indicative of a high level of concern amongst practitioners about the potential risks of speaking out in an atmosphere that is intolerant of dissent and which has been described by Bevan and Hood (2006) as characterised by 'targets and terror'.

[I]n a very tribalistic way... 'It's us and them, we had the power, we lost it, now they've got it'. [...] But actually, it's kind of a... it's an illusion anyway. It's not a... [long pause]... in terms of, you know, the way power is shared around in the health service, these aren't horizontal divisions, it's not this profession or that profession, it's bosses and workers. [...] Maybe it becomes more... you know, more emphasised in a time of recession, rather than in a time of expansion... so I don't know, I suppose, to some extent, the health service has expanded... in some ways after '97 and it's retracting now and so... you know, in those circumstances, the actions of bosses are more likely to come into conflict with the interests of workers.

Reflecting on the reasons for this 'tribalism', James comments:

I'd over-identified with psychiatry or psychiatrists as a... you know, as a, with an identity, as a grouping, as a kin... and... and I think that was a kind of entrenched or defensive retreat, in the face of, you know, the barrage of work and just the stress, so using my, just thinking about myself as case material then, what does that mean for health workers as a whole, is this what people do, they retreat into, you know, polarised identities... they're forced into it. (James interview 2, p.1-3)

A similar process is apparent in relation to Roger, a CMHN and the Unison trade union representative for the nurses in the team. Roger was frequently critical of the influence of 'social services' and seemed to apportion blame for the issues argued in this thesis as an outcome of neoliberal managerialism at the door of what I have proposed as one of its effects: increased integration and genericism. And yet, on exploring this with him, he set out a more nuanced position. Roger recounted his work with the Early Intervention Service (intensive support to young people experiencing psychosis) before he was transferred over to Southville CMHT. He told me that he had 'loved' this role and lauded the fact that he was able to "see people [service users] three times a week". He went on to bemoan the fact that he was now required to spend much more time on the computer, the 'desk nursing' described earlier by Phil, with a significant reduction in client contact in the context of a more generic role. Roger went on to explain to me that he had:

“[L]iked the way it used to be. I do the nursing, Kerry [OT] does the work thing, you [social worker] do the social, not this generic thing”. Roger paused to reflect on this. He asked me if I was old enough to remember the introduction of the purchaser/provider split in social work. He began to explain that he had known a really experienced social worker back in the 1990s called Fred Fletcher. Fred had described to Roger the damage the purchaser/provider split had done to social work. Fred told him “I can't do this job anymore. My whole career, it's finished”. Roger looked away, his expression one of frustration tinged with sadness, before adding: “I've turned into Fred Fletcher”. (Fieldnotes, 27.11.09)

Roger links his current experience of an intensified requirement to produce and manage data with the effects of genericism. However he goes on to imply a broader connection between these new pressures and the market reform of services that forms part of the neoliberal restructuring of the statutory mental health field. Subsequently, as described in Chapter 8, Roger began organising forms of horizontal solidarity with social workers as a challenge to these processes.

Other examples of these processes, also illustrated in Chapter 8, are apparent in response to the effects of managerialism at the meso organisational level. Practitioners described the generation of a tendency towards a bio-medically reductive practice: ‘the business end’ constituted by the monitoring of ‘meds, mood and sleep’ that is produced by strenuous welfarism in combination with the pressures to engage in defensive risk management. However, the chapter also noted opposition to this both at individual and occupational levels. At the individual, or micro level, Southville team members expressed concern that recovery has become a paperwork process rather than value-driven practice, and consternation at senior management injunctions to practice in person-centred ways when their aspirations to engage in relationship-based and community-oriented forms of practice were so constrained by managerialist structures. Examples of practitioner engagement in

small-scale forms of resistance to this through individual casework and egalitarian forms of group and community work were given. In this regard the defence of professionalism as occupational autonomy grounded in a commitment to user-centred practice can be seen as constituting a challenge to managerialism. However resistance at the meso level has also been described. The possibility of horizontal forms of solidarity both between occupational groups in the face of the demands of strenuous welfarism and alongside service users, for instance in the campaign against the bed reductions and closure of the walk-in service, evokes the progressive impulse or 'radical kernel' contained within welfare professionalism (Ferguson, 2009).

These examples highlight the forms of agency emerging at the micro (and meso) level in response to meso level processes that are reshaping the interaction of occupational groups within a reconfigured organisational environment. This suggests two inter-related processes. First, that managerialism at the organisational level tends to suppress the specificity of professions as many occupational roles take on a more generic character. Second, that an emergent potential of this is the mobilisation of solidarity across occupational groups (and with service users) in defence not only of services in a period of austerity but also of professional identities that are constituted by both autonomy and an ethical orientation. The resistance is underpinned by concern that such forms of professionalism are destabilised by an orientation to the needs of target-driven organisations rather than those of service users.

9.5 Summary: reflections on the reconstructed pentimento

This chapter has drawn on the analytical strands emergent from data collected with practitioners, service users and carers linked to a particular mental health team, Southville CMHT, in order to develop a contextually-situated understanding of the ways in which forms of mental distress are conceptualised in the field. The analytical framework of the pentimento has been reconstructed utilising Bhaskar's notion of the laminated system to incorporate both diachronic (spatio-temporal) and synchronic (including micro-macro scale) considerations. This has enabled a more satisfactory conceptualisation of the dynamic relationship between actors in the field, forms of knowledge and the context of action. The data from the study has supported the assertion that traces of the Keynesian welfare stratum and its associated forms of practice and knowledge co-exist with earlier strata but that the more recently emergent layer of neoliberalism is increasingly predominant in this field.

Moreover, the development of a conception of different levels of scale, from political-economy at the macro, occupational and organisational processes at the meso, to the micro level of the situational has facilitated a more satisfactory account of the stratification of the structural context and the enablements to and constraints on the activity of individual and collective agents that arise from this.

At the meso level, organisational and occupational change is apparent in restructuring of labour processes by management and policy actors in accordance with the requirements of dominant welfare regimes, and in new forms of inter-

professional and service user-practitioner relationship. 'Gestures' in the form of individual agency at the micro level are visible here but also collective agency and resistance in the form of mobilisations around the interests of occupational groups, carer networks, service user movements, and class-oriented practices of trade union struggle. As such, activity at these meso and micro levels is shaped by, but also itself reshapes the institutional context of practice. Moreover this also suggests that, whilst the activity of practitioners and service users leads under conventional conditions to the structural reproduction of the service context, these latter forms of individual and collective agency may also offer at least the potential for structural transformation of this field.

10. CONCLUSION

10.0 Introduction

Having presented the case for the development and extension of the theoretical framework of the penitimento in the preceding chapter, I will now provide concluding reflections on the findings, process, methodology and political context of the study.

Before proceeding I will restate the study's key objectives in order to provide some context for the evaluation of aspects of the thesis in this chapter. As noted in Chapter 1, the central aim of the project was to explore the expression and negotiation of differing conceptualisations of mental distress within multi-professional CMHTs, and consider the articulation of social perspectives within this. This overall aim had four key dimensions:

- To identify which theoretical models of mental distress inform professional practice in community mental health teams.
- To explore how articulation of these models relates to their contextual situation within environments shaped by occupational, organisational, policy and wider socio-economic processes and the relative power relationships arising from these.
- To examine the implications of these processes for social perspectives within mental health practice, and the impact on the experiences of service users, carers and frontline practitioners.

- To contribute to an emerging methodological approach that combines reflexive ethnography with a critical realist epistemology.

In the first section I will address points 1 and 2. Following this in the second section I will attend to point 3 by considering the implications of contemporary policy for the development of a more socially oriented practice and democratisation of the mental health field. The third section will consider point 4 via reflections on the research process and the contribution of the methodology to meeting these objectives and discuss directions for future research. The final section will provide a brief summary of the thesis and its key implications.

10.1 Developing a contextually-situated understanding of models of mental distress

It has been argued that the reconstructed pentimento framework enables a more situated understanding of conceptualisations of mental distress. This section will reflect in particular on the implications of the proposed relationship between the concepts and activity of practitioners and service users and multiple and interacting levels of contextual determination for agential activity within this domain.

The thesis has sought to demonstrate, in opposition to static conceptions of mental distress, that there is a dynamic process within practice whereby practitioners move strategically between different ideological positions (strata) according to the demands of the context. This is apparent in Chapter 6 where psychiatrist James moves between the custodial and community care strata as he seeks to intervene with Manu.

He explicitly problematises a neoliberal consumerist orientation, and mobilises the sick role position instead. However CMHN Abbie's perspective contrasts with this, as she tends to responsibilise Manu through the concept of 'personality', though she is also positioned within the therapeutic-community care stratum. In Chapter 7, social worker Filipe adopts a fervent therapeutic-community care stance. This is in tension with James who orients towards the biomedical, but also between this and the community care stratum and user-involvement/consumer strand of neoliberalism. Filipe later shifts his positioning towards the risk dimension of the neoliberal stratum that legitimises a biomedical orientation in relation to service user Alistair. The argument of the thesis is that the differentiated strata and levels within the pentimento can assist in developing a firmer understanding of these oscillations, and this will now be set out.

The pentimento strata represent a range of ideological positions linked to the historical development of mental health institutions that uneasily co-exist (the diachronic dimension). However, the theorisation of levels of scale (the synchronic dimension) enables greater differentiation of processes within the strata. The meso level of organisational and occupational processes is particularly important here. Practitioners tend to position themselves within the strata in ways that relate to their occupational identity and knowledge base, and within the institutions of the community care stratum a greater degree of professional autonomy was available to practitioners to do so. However, the emergent neoliberal stratum is reshaping organisational dynamics via 'strenuous welfarist' forms of managerialism. As a result greater constraints tend to be exerted on professional discretion as practice

configurations become more genericised through care pathways and audit. What is visible in the scenarios described in Chapters 6 and 7 is an initial divergence between James, Abbie and Filipe's perspectives linked in part to differing *occupational* epistemologies at the meso level. However there is a convergence in the strategies accepted by these practitioners as perceptions of risk become prominent. In both situations the requirements of the 'defensive' *organisational* context of neoliberal services are apparent. These case studies suggest therefore that when tensions emerge between meso level organisational and occupational processes within the neoliberal stratum, that organisational exigencies tend to prevail.

However Rhodes (1993) describes tensions between determination within these strata of the pentimento and the gestures or agency of practitioners. She conceptualises agency in terms of the strategic manoeuvres of mental health workers, but this tends to operate at the individual level within the constraints transmitted by the sedimentation of the institutional context. The argument of this thesis, drawing on examples presented in Chapter 8, is that while the activity of practitioners and service users typically tends to reproduce the institutional context, under certain conditions both individual and, crucially, collective forms of agency have the potential to construct new modes of engagement and transform the institutional setting itself. At Southville CMHT the effects of the organisational processes linked to the neoliberal stratum described above were generating forms of resistance. These were sometimes linked to opposition to genericising trends within managerialism that reduced occupational autonomy, and thus can be conceived as attempts to defend forms of practice linked to the community care stratum. However, identification with

developments related to service user movements at the individual level through modes of engagement such as the 'hearing voices' approach, and at the community level through the Mental Health Matters workshops suggest the possibilities for new forms of practice. These acknowledge the oppressive dimensions of earlier institutional forms of community care and thus seek to move beyond them to realise the more universal, democratic and egalitarian potentialities contained within it that are undermined by the emergent neoliberal stratum with its emphasis on risk and responsibilisation. These possibilities will be explored further in the next section.

In summary, it has been argued that the theoretical framework developed in the thesis, the reconstructed pentimento, facilitates the explanation of causal processes over time at multiple and interacting levels of stratification through the incorporation of diachronic and synchronic dimensions. This framework is thus able to maintain a balance between contingency and determination within a dynamic totality. Forms of agency were also considered and the implications of these for more holistic and egalitarian orientations in practice will now be considered.

10.2 Proposals for social perspectives and resistance

The emergence of the currently predominant neoliberal stratum has been described and problematised in this chapter and throughout the thesis. Evidence has been presented that suggests this stratum constitutes an obstacle to the promotion of holistic, relationship-based and collective forms of practice oriented to values of social justice. However the study has aspired not only to develop theory but also to

make a contribution to contemporary debates around the value and the promotion of social perspectives for understanding and responding to mental distress. Therefore, in this section the prospects for such perspectives and democratisation of the field will be considered.

The creation of the spaces in which social models of distress may emerge is likely to be facilitated through processes of democratisation within services and the wider society (Beresford, 2004). However Pilgrim and Tomasini (2012) have noted that the lay responses to the 'unreason' associated with madness and distress, particularly in relation to risky behaviour, may present an obstacle to transformative alliances of resistance between survivors and potential allies such as the disabled people's movement. For this reason they note the importance, if conceptual alignments with the social model of disability are to be possible, of critical reflection on the nature of a mentally enabling society and on moral accountability in the context of psychological difference.

Whilst such work is crucial it is most likely to require consideration as practical questions emerge in the course of political contestation. I argued in Chapter 4 that dominant welfare systems are never homogeneous and therefore always generate tendencies towards such countervailing concepts and activities 'from below'. These arise in direct challenge to dominant welfare practices and, as such, form the 'kernel' of radical alternatives to them (Ferguson, 2009). Though I argued that these are relatively marginal at the present conjuncture, they are nonetheless visible in mental health settings such as Southville CMHT. Examples provided included forms of

person-centred and relationship-based practice, small-scale resistance via challenges to managerial priorities, community engagement and involvement in collective forms of mobilization such as trade union activity and political campaigning alongside service users and in wider movements.

It is not the argument of this chapter that small-scale forms of mobilisation, in isolation, will be sufficient to achieve a fundamental democratisation of the mental health field and transform models for understanding and responding to mental distress. Moreover, the critique of the emergence of the neoliberal stratum does not imply an argument for a return to an idealised Keynesian welfare stratum. The oppressive dimensions of this model have been extensively identified (Ferguson et al., 2002). However the universalist *potential* of this form of welfare state was unrealised. In problematising both the oppressive nature of the Keynesian (and neoliberal) welfare state but thereby struggle for its greater democratisation the aspirations of universalism might be more effectively attained. The struggles of service users and their allies for new participatory forms of welfare will be central to shaping such an 'emergent culture' (Beresford, 2012). These activities and alliances suggest potentialities for a different kind of mental health practice oriented to more holistic and egalitarian forms of engagement. Whether or not these will be realised will depend on the outcome of the wider processes of social and political contestation to which these activities contribute.

Having considered the implications of the study for practice, policy and resistance the chapter will now conclude with reflections on process and methodology.

10.3 Reflections on research process and methodology, and directions for future research

This section will provide a reflexive account of the ethnographic research process, at its conclusion, that builds upon the discussion in Chapter 5. It will provide an outline of the study's development over time, with a particular focus on how the recurrent interaction between my biography, experiences and relationships in the field and theoretical reflections shaped the reconstruction of the pentimento framework and the arguments presented in the thesis.

While the mode of presentation of a study such as this almost inevitably offers the impression of a straightforward linear process, in this case it was fundamentally both an iterative and, as Pearson (1993) notes, a 'messy' one. My theoretical starting point was informed in many ways by my identity as a mental health social worker. My experience of debating and disagreeing with colleagues in psychiatry regarding the most effective ways of understanding and responding to mental distress whilst working in statutory and voluntary sector services led to a belief that social and progressive responses to such experiences were most likely to be realised through the foregrounding of the social work role. Of course this was relatively implicit, and also challenged by my understanding from practice and activist experience that psychiatrists and other occupational groups in the field had developed significant social and critical perspectives and interventions. My increasing contact with the ideas of the disabled people's and survivor movements further destabilised these

assumptions. However, on beginning to develop this project, I nonetheless retained at least in part the assumption that models of mental distress should be understood straightforwardly as expressions of the professional knowledge bases and ideologies of key occupational groups within the field, and for this reason that the positioning and intervention of social work was of particular relevance in view of its social and sociological orientation. My experience during the pilot study at Northville CMHT to some degree reinforced this notion. A split between nurses and social workers was explained to me as a reflection of the tensions between medical and social models by one social worker there. Moreover it is worth reflecting at this point that this confidence was shared with me because of my identity as a social worker, highlighting the consequences of one's positioning in the field for data collection.

While this idea of the relationship between models and occupational affiliation persisted it sat uneasily alongside my lived experience of practising in teams with colleagues who did not conform to such simplistic stereotypes. Moreover my observations at Northville had also suggested that the tensions there bore some relation to organisational processes. The team's manager and deputy were both social workers and this broke a convention within the Trust that these CMHT roles would be shared with one from each occupational group. As the study progressed I was further disabused of any lingering assumptions of the straightforward 'social worker = social model' type that remained. At Southville CMHT I noticed that practitioner participants from social work and nursing might challenge practices such as diagnosis, for instance when social worker Farooq privately expressed disagreement with the label of 'catatonic schizophrenia' attributed to one of his

allocated service users, or when CMHN Roger used the phrase 'diagnosis human being' to satirise biomedical reductionism. However, as noted earlier, at various points both contradicted these apparently unambiguous orientations. These tensions formed part of the emergent problematic that the study has sought to address: to develop an understanding of the processes shaping the practitioners' oscillations between different ideological positions.

The discussion of data analysis in Chapter 5 highlighted the process through which Rhodes' (1993) pentimento was identified as a means to assist with and orient the analytic work. I will briefly reprise the key stages here to illustrate the iterative nature of the development of the adapted pentimento.

After the initial stages of fieldwork with Southville CMHT, as analysis progressed alongside data collection in the field the pentimento was identified as an orienting conceptual framework and seemed to offer an extremely useful lens for understanding practitioners' thinking in context. However there were still gaps. Confinement, biomedical and community-systemic modes were all visible in the field but others too. Further analysis highlighted practitioner focus on risk in ways that seemed different from earlier custodial orientations. Also visible in the data was the embedding of the market and consumerism within mental health settings and the way this shaped a new conception of user and carer needs and their relationship to services. These prompted the development of new clusters of core codes during analysis. Following further theoretical reflection I proposed two new layers of the pentimento: risk, and marketisation in addition to the three developed by Rhodes.

The next stage of data collection, in-depth interviews, revealed similar movement between ideological positions but also connections between the newer layers. Interview data also highlighted themes such as user involvement, recovery and 'hearing voices' approaches influenced by user movements. While these were present in the earlier analysis they had been insufficiently theorised within the model. As a result I proposed a third additional pentimento layer: service user involvement. In view of the emergence of these strata within a similar timeframe it seemed they might represent differentiated facets of a broader shift within the form of welfare state as neoliberal policy reshaped this field. Reflection on extant theory, in particular Callinicos (2001) and Mooney (2006), helped me to make the links between neoliberal welfare policy and its authoritarian strand to connect risk and the market, but this framework did not fully crystallise until I encountered Brown and Baker's (2012) text on neoliberal responsibilisation in mental health services. This assisted me to conceptualise the link between the promotion of user involvement as consumerism, and the coercion of those unable or unwilling to adapt to this new marketised environment. Consequently these three new layers were reconfigured as interacting dimensions of one new stratum: neoliberalism.

The title of the thesis 'the business end' using a quote from CMHN Kath is intended to evoke the interaction of these three dimensions of the neoliberal stratum. The first way in which it does so relates to Kath's apparent meaning when she used this phrase. She sought to convey that she felt forced to adopt an inquisitorial approach checking risk factors (mental state and medication compliance) when meeting with

service users because of the prevailing 'defensive' atmosphere around risk issues, and the time constraints she experienced because of other neoliberal managerialist demands. However there is a second sense in which this phrase is suggestive of the neoliberal stratum. The sense of many team members was that the space for longer-term relationship-based work oriented to understanding meanings of users' experiences was closing down with the 'end' of the CMHT model and its more casework and community-oriented approach. The 'death throes' described by CMHN Roger were prompted by the introduction of new modes of practice consistent with a short-term, individualised and 'responsibilised' welfare, the standardised care pathways and clusters of payment by results. The third dimension evoked by the quote is that of business itself, the experience of transfer from a public service model to a new competitive mental health service environment where talk of 'tariffs' and 'market leaders' becomes commonplace.

There was yet another form of reconstruction required during this process. I did not regard Rhodes' pentimento, developed within a Foucauldian archaeological orientation, as satisfactorily conceptualising ontological stratification and emergence. Moreover, while Rhodes' pentimento did incorporate a conception of agency and structure in the form of gesture and strata respectively, this tended to under-theorise agential capacities and structural elaboration. For this reason I turned to Bhaskar's critical realism, using this to provide firmer epistemological and ontological foundations. However my reconstruction of the pentimento involved more detailed work than anticipated. Though I found Bhaskar's (2010) work on philosophy of science, in particular interdisciplinarity and emergence, to be of great value in this

task I also regret not engaging with the more sociologically oriented CR work of Margaret Archer (1995) at an earlier stage. The latter was ultimately extremely helpful in developing the notion of the four new strata (conceived as ‘conjunctural welfare settlements’ drawing on Harris, 2008) that condition and shape the activity of practitioners, service users and others. However I feel further work will be needed to sharpen the distinction between primary and corporate agency, utilising Archer (1995), and also Creaven’s (2000) development of Archer’s work in terms of collective class agency, in preparation for the future publications that will hopefully arise from the thesis.

Another way in which CR has proven invaluable is in the theorisation of a dynamic interactive totality. This, as the thesis has argued, enables static reified conceptions of models of distress to be avoided. Moreover it helps to explain the way in which older conceptions such as the biomedical model are remobilised in the contemporary context, as the biomedical orientation is compatible with a more individualised and coercive context. The same processes are visible in the way that recovery approaches are appropriated by managerialist processes. The reconstructed pentimento helps in the conceptualisation of these variegated processes, but is indebted to CR for assisting in unpacking the complexities of determination at multiple interacting levels in a field such as a mental health team, enabling both determinism and voluntarism to be avoided.

One relatively novel methodological feature has been the combination of CR and ethnographic methods. CR is underpinned by the ontological assumption of an extra-

discursive reality, and thus the study deployed concepts such as 'social structure' and 'level'. However while this enabled examination of practitioner, service user and carer meanings in relation to their material and historical context, three particular tensions and limitations arising from ethnographic work informed by this methodological stance should be acknowledged.

The first is that such concepts are strongly contested within dominant interpretivist/constructivist ethnographic traditions because, it is argued, accounts of 'structure' are assumed, they over-simplify the complexity of reality and the study of them is problematised due to their linguistic construction (Olsen, 2010). As a result ethnographies in these traditions have tended to focus on individual meaning making within the localised or micro context. This flags up a second challenge for CR-informed ethnography: how the wider context in which a study is situated should be defined (Hammersley, 2006). The placing of participants by the analyst in an 'external/macro' context not directly articulated by the actors themselves in the course of their daily activities (such as the neoliberal market system) might be considered by interpretivist ethnographers to be an illegitimate imposition. This leads directly to the third of the tensions: how knowledge of the macro context is to be gained. This may be difficult using a method such as participant observation. Thus questions are raised about whether wider social theory is an appropriate substitute for an empirical approach and, if so, on what basis such theory should be selected. Moreover this breaches another interpretivist injunction to generate theory inductively (Davies, 2008).

I acknowledge these tensions, but will respond to them utilising arguments initially developed in Chapter 5. First, while an understanding of the discourse and meanings of individual actors' is necessary for interpretive understanding it is not sufficient. This is because the interpretations of participants (and analysts) are partial, fallible and do not fully constitute reality. As a consequence my analytic work moved retroductively, using extant *and* emergent theory, from the events observed and participants interpretations to posit the generative mechanisms producing them. The mechanisms in both localised and wider contexts have been inferred from their effects where they cannot be directly observed. This acknowledges the interaction of individual agency and structural conditioning while avoiding structural determinism. While I recognise that these methodological choices are contestable, it is hoped that the practical adequacy of the account produced of activity and conceptualisations in the field provides sufficient warrant for them (Sayer, 1992).

A further tension is related to the ethical and political positioning of the study. I have argued for the need for an ethical research practice to take sides in the context of structural inequalities. However Hammersley (2006) has argued that overt political commitment on the part of the researcher presents the risk of systematic bias. Whilst I recognize this possibility, I would argue that political and value neutrality in social research is not possible. Instead a reflexive stance and transparency in data collection and analytic practice enables judgements to be made concerning potential bias (Davies, 2008). I have therefore sought to make relevant information available for scrutiny in the methodology chapter.

Nonetheless, my political stance had implications both in terms of field relations and in the analytic work. In relation to the former, my activist identity shaped the kind of interactions that developed in the field, and the kind of data revealed to me (the example of Roger sharing trade union information is one example). The nature of the data collected necessarily oriented the way in which the theoretical framework developed. On reflection I may have added negative case analysis to address this. One example was Daphne, a social worker based in Eastville CMHT (the other team based in the same building as Southville), who explained to me at length one day the benefits of the short-term and clinically oriented pathway approach of CMHTs in New Zealand where she had spent several years working. In this way, alternative perspectives on managerialist reforms might have been examined in greater detail. In addition to this I might also have engaged in member checking during the analytic process to assess the theoretical validity and potential bias within emergent conceptual frameworks. Moreover, the adoption of a participatory research design might have enhanced validity, and also satisfied CR's ontic commitment to human equality by avoiding the construal of participants as passive subjects (Olsen, 2010; Cruickshank, 2003). Nonetheless it is hoped that feedback from participants at presentations of the study's findings will facilitate theoretical refinement as I move towards publication.

Further dilemmas emerged as a result of the vast volume of data generated by multiple methods. I had to make difficult choices about what it was possible to analyse and include in the thesis. Eventually decisions were made on both methodological and pragmatic grounds.

The methodological rationale for the selection of data to present has already been set out in Chapter 5. This was facilitated by the timing of the fieldwork at Southville CMHT, during a period of transition for the team to the RiO database and towards implementation of PbR. The effects of these major reconfigurations of the labour process were detailed in Chapter 8. They generated significant challenges for, and strains on, practitioners, and this impacted on those using services too. As a result of these 'crisis situations' the generative mechanisms shaping the organization of practice in the setting became more clearly visible enabling their retroduction and the development of the theoretical framework. Similarly, the crises unfolding in the two case studies elaborated in Chapters 6 and 7 facilitated a retroductive analysis to increase understanding of the mechanisms shaping conceptualisations of mental distress. It is, though, a matter of regret that this understanding came at such a significant cost to participants in the field.

The case studies elaborated in Chapters 6 and 7 were also selected on pragmatic grounds. They represented two of the limited instances where I was able to collect data relating to particular service users in more than one setting and in interaction with more than one practitioner. While I had set out with the intention of collecting data in this clustered way to explore multi-disciplinary interactions, the nature of the reconfigurations described above reduced practitioners contact time with service users, and their opportunities to attend multidisciplinary fora and engage in joint working with colleagues. This, in turn, impacted on the type of data I was able to collect in the field. These constraints on practitioners were captured in my

observations but also supported by reflexive data. Two practitioner participants emphasized how much they valued the space to engage in detailed discussion of their understandings of the needs of particular service users with me during the fieldwork and in research interviews because it was now so rarely that they had the opportunity to reflect on their work in dialogue with other team members.

Nonetheless it is important to critically reflect on the consequences of selecting these particular case scenarios for detailed exploration. Perhaps the most significant relates to gender, with both case studies focused on a male service user. This reflects the sample, with only 3 female service users recruited to the study out of a total number of 28 participants at Southville CMHT in spite of evidence to suggest the gender composition of users of CMHT services is evenly balanced (Greenwood et al., 2000). Noting this imbalance in recruitment during the middle stages of data collection, I positively encouraged practitioners to approach female users. However, while only one team member explicitly identified gender as potentially problematic in view of her female service users' histories of sexual abuse and my identity as a male researcher, it is possible that gender was a tacit factor for other practitioners. A related issue is the presentation of the interview data from only one service user and carer. While it is difficult to assess the specific implications of these limited representations of service user, in particular female service user³⁴, and carer voices for the theoretical model developed this remains a significant potential limitation.

A second critical reflection relates to the retroductive rationale for the selection of

³⁴ There are some brief reflections below on the implications for the pentimento model of structural dynamics such as gender and race

crisis scenarios to present in the thesis. Lipscomb (2006, p.363) notes the criticism developed by Bernstein (1976, p.10) that the “interpretations and explanations [retroduction produces] are frequently so flexible, vague, or open that they can ‘account’ for almost any data.” This highlights the question of how the researcher might distinguish mechanism driven events from mere contingency, and mechanism (social structure) from context. This reveals potential ambiguities in the present study. For instance in the adapted pentimento framework it is argued that professionalism and managerialism constitute mechanisms inter- and counter-acting at the meso level. Moreover there are also countervailing mechanisms - competing models of distress – associated with the spatio-temporally emergent institutional contexts of the biomedical, community care and neoliberal systems. However while these spatio-temporal strata are understood in the latter formulation as context they might also be construed as mechanism (social structure) insofar as they provide rules and resources that engender certain forms of action. Arguably the laminated system enables a phenomenon such as ‘community care system’ to be broken down into interacting mechanisms at different and nested ontological levels to enable greater specificity in differentiation of context from mechanism/structure (New and Carter, 2006) but, nonetheless, this highlights a significant tension for the model.

Finally there were a number of interesting themes in the data that could not be explored due to limitations of space in the thesis. The first and most significant is the relationship between issues of race, class and gender and the layers of the pentimento. The case studies of Manu and Alistair illustrate the ways in which

conceptualisations of these structural dynamics are rendered practically invisible in the neoliberal transition and this warrants closer and more detailed interrogation.

The neoliberal welfare settlement is premised upon increased personal responsibility and declining collective provision (Mooney and Neal, 2010). In the field of mental health provision this has involved the promotion of individualised ways of understanding and responding to mental distress that adapt and reinforce earlier biomedical frameworks (Moncrieff, 2006). This tends to marginalise recognition of social determinants of and social perspectives on mental health and distress (Navarro, 2009; Ramon, 2008). In this context articulations of the structuring of mental health needs in relation to class, race and gender tend to be marginalised.

One example of this shift from a community to individual focus in practice is the marginalisation of structurally focused community work with BME groups (described by Farooq in Chapter 8). In parallel with this there was a renewed emphasis on individualised casework via care pathway models implemented to facilitate PbR. This could be characterised within the adapted pentimento framework as representing a shift from Keynesian community care to the neoliberal stratum. However the failure to address inequality alongside gender, race and other forms of oppression in the Keynesian model and thereby realise its universalist potential was noted earlier (Ferguson et al., 2002). For this reason resistance at the micro (individual) but more significantly meso level in the form of collective social struggles to defend forms of community engagement may contribute to the development of a more genuinely universal orientation. In challenging the class inequalities and forms of oppression

such as sexism and racism that contribute to the aetiology of mental distress (Astbury and Cabral de Mello, 2000; Chakraborty and McKenzie, 2002; Murali and Oyeboode, 2004), such democratising struggles may themselves embody forms of transformative agency capable of reconfiguring ways of understanding and responding to mental health needs and creating new welfare settlements.

There are at least three further areas of potential interest that could not be explored due to constraints of space. The first would be to engage in a comparative analysis of data from Southville with Northville CMHT. Two particular dimensions would be the salience of apparently more intense interprofessional tensions in the former, and the way in which the presence of a clinical psychologist based with the team impacted on the articulation of models. The second would be to examine the relevance of the pentimento in other service contexts, for instance those where non-professional occupational groups such as Support, Time and Recovery (STR) and community support workers predominate or in user-led services. The last of the recommendations would be to conduct a follow up study, in accordance with diachronic method proposed by Burawoy (2003). This would examine the impact of the clustering of service user need on conceptualisations of mental distress in the context of the service line management reconfigurations. I am currently in negotiation to set up access to Southville CMHT or, if it is not possible to return, another similar fieldwork site to facilitate this plan.

10.4 Concluding comments

This thesis has sought to argue that the processes shaping conceptualisations of mental distress implicate institutional and wider social contexts and are not merely the outcome of contestation at the level of ideas. The latter relies on a static, reified conception of knowledge. Instead the thesis has proposed a more dynamic, contextually-situated understanding of models of mental distress that overcomes these limitations. This model has been developed to integrate both diachronic (spatio-temporal) and synchronic (including micro-macro scale) dimensions. As a result practitioners and service users navigate a field in which forms of knowledge and practices related to the Keynesian community care stratum remain visible but are increasingly marginalised by three dimensions of an emergent neoliberal stratum characterised by marketisation, responsabilisation and risk, and the remobilisation of the earlier biomedical and custodial strata. The extension of this model to incorporate levels of scale enables analysis of the ways in which the articulation of these strata is shaped by the macro context of political economy, in interaction with the meso level of occupational and organisational dynamics and the micro situational level. These levels constrain but also enable the embodied agency of practitioners, service users, carers and other individual and collective actors. This typically leads to systemic reproduction but also has the potential for transformation of the field through forms of resistance.

In the current conjuncture of neoliberalism the requirements of capital for an extension of the conditions for accumulation into ever-wider layers of the social fabric

(including the public sector) predominates making such resistance more urgent. The incremental shift towards NHS marketisation since the early 1990s has culminated in the reconstitution of the NHS as a commercial market realised through the Health and Social Care Act 2012 (Pollock and Price, 2011; Pollock and Price, 2013). Payment by results is an important dimension of this marketisation project as noted above. Meanwhile within social services the implementation of a market model has taken place over the same period but in an accelerated form, starting with the purchaser-provider split through to the more recent introduction of individual budgets (Harris, 2003; Ferguson, 2007). The implications of these reforms for equitable access to services are profound. As Mandelstam (2007) notes, while policies such as personalisation may benefit some, this is realised at the expense of universality and comprehensiveness.

As a result of these social and political changes, mediated through and magnified by their impact on health and welfare services, increasingly stark inequalities in the distribution of resources and power are apparent, with all the toxic effects so thoroughly described by Wilkinson and Pickett (2011) in their seminal text.

Meanwhile, and related to this, forms of discrimination and oppression that represent such a challenge to the physical and psychological wellbeing of citizens persist. As a result it would appear that a neoliberal orientation in mental health policy and practice is inconsistent with greater democratic control, and that socio-political change will be required to wrest back more egalitarian and socially just relations within this domain and society more generally.

The growing emphasis on coercion and marginalisation of socially oriented and relationship-based work in the neoliberal moment has prompted criticism from users of mental health services (Beresford, 2005; Beresford et al., 2011) who value the friendly relationships and humanity of workers (Beresford et al., 2008). Mental health practitioners have also consistently expressed a desire to work in democratic and participative ways with service users (Ferguson, 2008; Bracken et al., 2012). It is from this shared interest in developing more socially just forms of mental health practice, so threatened by neoliberal reform, that alliances between workers and service users have the potential to emerge. Hierarchies in the labour process can divide social workers, nurses and psychiatrists, as do power imbalances between service users and practitioners. However, finding common ground in the struggle for more comprehensive, but also more egalitarian and democratic mental health services could provide a crucial element in overcoming these obstacles to building alliances of resistance. Such developments have the potential to produce not only new ways of conceptualising mental health needs but also ensure that the current epidemic of mental distress is curtailed through a transformation of the conditions in which it emerges.

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APPENDICES

APPENDIX 1A: INFORMATION SHEET FOR NORTHVILLE CMHT PRACTITIONERS

NHS Trust Logo

Participant Information Sheet for Staff and Students

Title: A study of communication within a Community Mental Health Team (CMHT)

Invitation to take part in the study

I would like to invite you to take part in a research study. In this leaflet I will explain the research and what it would involve for you. Please feel free to contact me via the telephone number or email address provided below if there is anything in this information sheet that is not clear or if you would like further details.

What is the research about?

The aim of the study is to develop knowledge of the way in which mental health care and support is provided by statutory services. In particular, I am interested in how mental health workers negotiate an understanding with service users and their carers of the mental health needs of users. I am also interested in how professionals share and negotiate these understandings with each other. The study will seek to provide an insight into the realities of inter-professional working and changing professional roles in statutory mental health settings. I wish to undertake research that gives expression to the skills, complexity and challenges of frontline mental health practice, and the way competing pressures, responsibilities and obligations are managed by professionals.

The purpose of this research is primarily educational and the findings will be written up as a dissertation for the MA Applied Social Research course at the University of Birmingham. The research will also serve as the pilot study for a PhD.

Why has this team been chosen?

I am a social worker who has worked for XXXXXXXXX for the past 2 years in the XXXXXXXXX. As I already have established relationships with staff and service users in XXXXXX, I decided to conduct this research with a team in XXXXXX. Researcher colleagues within the Trust recommended XXXXXXXXX.

Do I have to take part?

Participation in this study is entirely voluntary, and you may withdraw at any time.

How will the research be carried out?

My plan is to use an ethnographic approach. I hope to get a feel for the work of the team and build up a picture of interactions between professionals and service users in their day-to-day context. This means that I will not be asking professionals to take time out from their normal routine. Instead it means that I will be spending time alongside staff as they carry out their usual tasks. This will include coming along to staff meetings, CPA meetings, ward rounds, home visits and meetings with service users at the office. I will later make notes of my observations, which will then be analysed to produce the findings.

What am I requesting from the team?

I would like to seek your consent to spend time alongside the team for four days per week over two months, from June until August 2008. I would also appreciate your assistance in identifying users and carers who would be willing to participate. All participants including staff will be asked to sign a consent form. A copy of the signed form will then be given to each participant to keep.

What are the possible disadvantages or risks of taking part?

Participants will be engaged in their usual practice routine whilst I am present. It is possible that some participants may find being observed uncomfortable, however only those who wish to take part will be included in the study. As a social worker, I am aware of effective risk management practice, as well as the need for sensitive engagement in the event of participant distress.

What are the possible benefits of taking part?

The potential benefits will include the development of knowledge regarding inter-professional and practitioner-service user interaction and negotiation. It is hoped that the feedback process will provide an opportunity for the team to reflect on and discuss these issues.

What if there is a problem?

If you have any concerns about the conduct of the research or wish to make a complaint, please contact the administrator at the Centre of Excellence in Interdisciplinary Mental Health at the University of Birmingham on [REDACTED] who will forward your concerns to the centre management.

Will my taking part in this study be kept confidential?

All information which is collected during the course of the research will be kept strictly confidential, and all recorded information will have names removed so that individuals cannot be recognised. Data collected will be anonymised and stored on a password-protected computer in accordance with the Data Protection Act 1998. As principal researcher, I will be the only person with access to this data. In case of risk of serious harm, the limits of confidentiality appropriate to professional practice will be applied.

What will happen after the research is complete?

I will write up a report as a dissertation for the MA Applied Social Research course, and would be willing to provide a presentation of the provisional findings to the team.

As a pilot study, the study will also inform how I approach the PhD research. I eventually hope to publish the findings of the PhD study to inform debate about contemporary mental health service provision and policy/practice development.

Who is organising and funding the research?

The Centre of Excellence in Interdisciplinary Mental Health at the University of Birmingham (ceimh.bham.ac.uk) provides me with a student bursary. This is the only source of funding for this study. XXXXXXXXX is supportive of the project, but the research is formally independent of the Trust.

Who has reviewed the study?

This study has been reviewed and given a favourable opinion by XXXXXXXXX Research Ethics Committee.

Contact details

If you require further information about the study or whether to participate, please feel free to contact me. My email address is [REDACTED], or you can call me at the University of Birmingham on [REDACTED]. Please leave a message and I will return your call as soon as possible. Further information about the Centre of Excellence in Interdisciplinary Mental Health at the University of Birmingham is available from www.ceimh.bham.ac.uk.

Thanks for your assistance.

Richard Moth
University of Birmingham

APPENDIX 1B: INFORMATION SHEET FOR NORTHVILLE CMHT SERVICE

USERS AND CARERS

NHS Trust Logo

Participant Information Sheet for Service Users and Carers

Title: A study of communication within a Community Mental Health Team (CMHT)

Invitation to take part in the study

I would like to invite you to take part in a research study. Before you decide I would like to explain why the research is being done and what it would involve for you. Please take time to read the following information carefully, and ask me if there is anything that is not clear or if you would like more information. I have used the term 'participant' to refer to people who agree to take part in the study.

Who is doing this research?

I am a researcher based at the Centre of Excellence in Interdisciplinary Mental Health at the University of Birmingham (ceimh.bham.ac.uk). I also have experience of working as a social worker with XXXXXX.

What is the research about?

I am interested in how mental health services work. This includes how mental health workers talk with service users and carers about their needs, and how this is affected by the responsibilities workers have and the pressures they face. I am particularly interested in how workers and service users and their carers come to understand each person's mental health needs. I am also interested in how professionals discuss and agree this with each other. The study will help us to know more about the ways in which professionals work together, and how they work with service users and carers.

This research is primarily for educational purposes. The findings will be written up for the MA Applied Social Research course at the University of Birmingham. The project will also form the first stage of a PhD research project.

How will the research be carried out?

I would like to come along with your mental health worker when they have meetings with you at home or at the office, including CPA meetings or ward rounds. I hope to get a feel for the work of the team and build up a picture of everyday communication between professionals and service users. I will later write up notes to help my understanding of what has gone on in the meeting, which will then be analysed to produce the research findings. The research will take place from June until August 2008.

What will participants have to do?

You and your mental health worker will meet with each other as usual, while I will come along to see what happens without actively taking part. I will not be asking you to take time out from your normal routine with your worker.

How have participants been chosen?

Your mental health worker has indicated to me that you might be willing to participate in this study. I am hoping that around five service users and five carers in total who are linked with XXXXXX will agree to take part.

Do those asked have to take part?

The choice of whether or not you wish to take part is entirely yours. I will describe the study and go through this information sheet, which I will then give to you. If you agree to take part I will then ask you to sign a consent form. However, if you don't wish to take part your service would not be affected in any way. Also, if you do agree to take part and then change your mind you can opt out at any time without giving a reason.

What are the possible disadvantages or risks of taking part?

The study involves me watching professionals working with service users and carers. I am aware that having an extra person at meetings observing may possibly be uncomfortable or difficult and I will be as sensitive to this as possible.

What are the possible benefits of taking part?

The aim of the study is to help professionals understand better what affects communication between workers and service users and carers. It is hoped that improving our understanding of these processes may help in developing more effective services.

What if there is a problem?

If you have any concerns about how this research is being carried out, or wish to make a complaint, please contact the administrator at the Centre of Excellence in Interdisciplinary Mental Health at the University of Birmingham on [REDACTED]. They will inform the centre management who will contact you to discuss these issues.

Will taking part in this study be kept confidential?

All recorded information will have names removed so that individuals cannot be recognised. Data collected will be anonymised and stored on a password-protected computer in accordance with the Data Protection Act 1998. As principal researcher, I will be the only person with access to this data. All information collected during the course of the research will be kept strictly confidential, unless you disclose that you, or someone else, is in immediate danger of serious harm. In such a case I would need to report that to someone who might be able to help.

What will happen after the research is complete?

I will provide a summary of the findings of the study in writing if you would like this. I will also produce a report for the MA Applied Social Research course. In addition, the study will inform how I approach the PhD research, the findings of which I eventually hope to publish.

Who is organising and funding the research?

The Centre of Excellence in Interdisciplinary Mental Health at the University of Birmingham (ceimh.bham.ac.uk) is providing me with a student bursary. This is the only funding for the study.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by XXXXXX Research Ethics Committee.

Contact details

If you require further information about the study or whether to participate, please feel free to contact me. If you have any questions I can come along with your worker to answer them, or you can call me at the University of Birmingham on [REDACTED]. Please leave a message and I will return your call as soon as possible. Further information about the Centre of Excellence in Interdisciplinary Mental Health is available from www.ceimh.bham.ac.uk.

Thanks for considering this request.

Richard Moth
University of Birmingham

APPENDIX 1C: CONSENT FORM FOR NORTHVILLE AND SOUTHVILLE



APPENDIX 1D: CONSENT FORM FOR NORTHVILLE AND SOUTHVILLE SERVICE
USERS AND CARERS



APPENDIX 1E: INFORMATION SHEET FOR SOUTHVILLE CMHT

PRACTITIONERS

NHS Trust Logo

Participant Information Sheet for Staff and Students

Title: A study of communication within two Community Mental Health Teams (CMHTs)

Invitation to take part in the study

I would like to invite you to take part in a research study. In this leaflet I will explain the research and what it would involve for you. Please feel free to contact me via the telephone number or email address provided below if there is anything in this information sheet that is not clear or if you would like further details.

What is the research about?

The mental health field is rapidly changing with a number of recent reforms to services including the promotion of recovery, increased service user involvement, changing professional roles and greater performance management. The aim of this study is to develop knowledge of the way in which mental health care and support is provided in this new context. In particular, the study will examine how this restructuring of the mental health field impacts on the various ways of understanding mental illness and distress utilised by practitioners, service users and carers, and how these perspectives are expressed and negotiated within teams. The study will seek to provide an insight into the realities of inter-professional working and to give expression to the skills, complexity and challenges of frontline mental health practice. This research is primarily for educational purposes. The findings will be written up as a PhD thesis at the University of Birmingham.

Why has this team been chosen?

XXXXXXX was chosen as I have links with this organisation having formerly worked as a practitioner within the XXXXXX. As I already have established relationships with staff and service users in XXXXX, I decided to conduct this research with a team in XXXXXX.

Do I have to take part?

Participation in this study is entirely voluntary, and you may withdraw at any time.

How will the research be carried out?

I will spend an extended period alongside the team in order to get a 'feel' for the way the team works and build up a detailed picture of interactions in their everyday context. This is called an ethnographic approach. This means that I will not initially be asking you to take time out from your normal routine. Instead it means that I will be spending time alongside you as you carry out your usual professional tasks. This will include coming along with you to staff meetings, CPA meetings, ward rounds, home visits and meetings with service users at the office. I will later make notes of my observations, which will be analysed to produce the findings. In addition I may seek

your permission and that of the service user to audio-record the meeting so I do not miss any important details. The notes and transcriptions from the meetings will then be analysed to produce the research findings.

At a later stage I may seek the opportunity to interview you about your experience of changing roles within the mental health field and how these impact on ways of understanding mental illness and distress. I will also access CMHT notes including CPA records and assessments for some service users with their consent.

What am I requesting from the team?

I am seeking your consent to join the team for four to five days per week from October 2009 until June 2011. If you agree to participate in the study I will ask you to sign a consent form and give you a copy of this to keep.

I would also appreciate your assistance in identifying service users and carers who would be willing to participate in the study.

What are the possible disadvantages or risks of taking part?

Participants will be engaged in their usual practice routine whilst I am present. It is possible that some participants may find it uncomfortable being observed, or in some cases recorded, however only those who wish to take part will be included in the study. As a former mental health practitioner, I am aware of effective risk management practice, as well as the need for sensitive engagement in the event of participant distress.

What are the possible benefits of taking part?

Although there may not be any direct personal benefits from taking part in the study, the research aims to improve our understanding of inter-professional and practitioner-service user interaction and negotiation, so it is hoped that this will contribute to the development of more effective services. I also hope that you will find the opportunity to discuss and share your knowledge about mental health and services to be a positive experience.

What if there is a problem?

If you have any concerns about how this research is being carried out, or wish to make a complaint, please contact the administrator at the Institute of Applied Social Studies, University of Birmingham on [REDACTED]. They will inform the Institute management who will contact you to discuss these issues.

Will my taking part in this study be kept confidential?

All information which is collected during the course of the research will be kept strictly confidential, and all recorded information will have names removed so that individuals cannot be recognised. Data collected will be anonymised and stored on a password-protected computer in accordance with the Data Protection Act 1998. As principal researcher, I will be the only person with access to this data. The limits of confidentiality appropriate to professional practice will apply, and I have a legal obligation to disclose information relating to unethical or criminal behaviour.

What will happen after the research is complete?

I will write up the findings as a PhD thesis, and would be willing to provide a presentation to the team. I eventually hope to publish the findings to inform debate about contemporary mental health service provision and policy/practice development.

Who is organising and funding the research?

I have developed this study with support from the Centre of Excellence in Interdisciplinary Mental Health. The Economic and Social Research Council (ESRC) provide me with a student bursary, which is the only funding for the study. XXXXXXXX is supportive of the project, but the research is formally independent of the Trust.

Who has reviewed the study?

This study has been reviewed and given a favourable opinion by XXXXXXXX Research Ethics Committee.

Contact details

If you require further information about the study or whether to participate, please feel free to contact me. My email address is [REDACTED] or you can call me at the University of Birmingham on [REDACTED]. Please leave a message and I will return your call as soon as possible. Further information about the Centre of Excellence in Interdisciplinary Mental Health at the University of Birmingham is available from www.ceimh.bham.ac.uk.

Thanks for your assistance.

Richard Moth

University of Birmingham

APPENDIX 1F: INFORMATION SHEET FOR SOUTHVILLE CMHT SERVICE USERS AND CARERS

NHS Trust Logo

Participant Information Sheet for Service Users and Carers

Title: A study of communication within two Community Mental Health Teams (CMHTs)

Invitation to take part in the study

I would like to invite you to take part in a research study. Before you decide I would like to explain why the research is being done and what it would involve for you. Please take time to read the following information carefully, and ask me if there is anything that is not clear or if you would like more information. I have used the term 'participant' to refer to people who agree to take part in the study.

Who is doing this research?

I am a researcher based at the Centre of Excellence in Interdisciplinary Mental Health at the University of Birmingham (ceimh.bham.ac.uk). I also have experience of working as a practitioner within XXXXXXXX.

What is the research about?

The way mental health services are organised is changing with a number of recent reforms. These include more emphasis on recovery, user involvement and setting targets for services alongside changes to the tasks that the different professions carry out. This study will look at the impact of these reforms on the way mental health practitioners work with service users and carers, and in particular on the way they understand mental illness and distress.

This research is primarily for educational purposes. The findings will be written up as a PhD thesis at the University of Birmingham.

How will the research be carried out?

I would like to come along with your mental health worker when they have meetings with you at home or at the office, including CPA meetings or ward rounds. I hope to get a feel for the work of the team and build up a picture of everyday communication between professionals and service users. I will later write up a record of this to help my understanding of what has gone on in meetings. These will then be analysed to produce the research findings. At a later stage I may also request to interview you or access your CPA and assessment notes.

This research will take place from October 2009 until May 2010.

Why have I been invited to take part?

Your mental health worker has indicated to me that you might be willing to participate in this study. I am hoping that around twenty service users and ten carers in total who are linked with the CMHT will agree to take part.

Do I have to take part?

The choice of whether or not you wish to take part is entirely yours. I will describe the study and go through this information sheet, which I will then give to you. If you agree to take part I will then ask you to sign a consent form. However, if you don't wish to take part your service would not be affected in any way. Also, if you do agree to take part and then change your mind you can opt out at any time without giving a reason.

What will I have to do?

You and your mental health worker will meet with each other as usual, while I will come along to see what happens without actively taking part. I will not be asking you to take time out from your normal routine with your worker. At a later stage I may request the opportunity to interview you about your experiences of using services or access your CPA or assessment notes.

What are the possible disadvantages or risks of taking part?

The study involves me watching professionals working with service users and carers. I am aware that having an extra person at meetings observing may possibly be uncomfortable. I will be as sensitive to these issues as possible.

What are the possible benefits of taking part?

Although there may not be any direct personal benefits from taking part in the study, the research aims to improve understanding of what affects communication between mental health workers, service users and carers and so it is hoped that this will contribute to the development of more effective services.

What if there is a problem?

If you have any concerns about how this research is being carried out, or wish to make a complaint, please contact the administrator at the Centre of Excellence in Interdisciplinary Mental Health at the University of Birmingham on [REDACTED]. They will inform the centre management who will contact you to discuss these issues.

Will taking part in this study be kept confidential?

Your name and details will not appear in the research report. All recorded information will have names removed so that individuals cannot be recognised. Data collected will be anonymised and stored on a password-protected computer in accordance with the Data Protection Act 1998. As principal researcher, I will be the only person with access to this data. Everything you say will be treated in the strictest confidence. The only exceptions are circumstances where I would be legally obliged to disclose information to the relevant authorities, or where you or someone else is in immediate danger of serious harm in which case I would need to inform someone who might be able to help.

What will happen after the research is complete?

I will provide a summary of the findings of the study in writing if you would like this. I will also report the findings in a PhD thesis, which I eventually hope to publish in journal or book form.

Who is organising and funding the research?

I have developed this study with support from the Centre of Excellence in Interdisciplinary Mental Health. The Economic and Social Research Council (ESRC) provide me with a student bursary, which is the only funding for the study. XXXXXX is supportive of the project, but the research is formally independent of the Trust.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by XXXXXXXX Research Ethics Committee.

Contact details

If you require further information about the study or whether to participate, please feel free to contact me. If you have any questions I can come along with your worker to answer them, or you can call me at the University of Birmingham on [REDACTED]. Please leave a message and I will return your call as soon as possible. Further information about the Centre of Excellence in Interdisciplinary Mental Health is available from www.ceimh.bham.ac.uk.

Thanks for considering this request.

Richard Moth
University of Birmingham

APPENDIX 1G: INFORMATION SHEET FOR SOUTHVILLE CMHT

PRACTITIONER INTERVIEWS

NHS Trust Logo

Participant Information Sheet for Staff and Student Interviews

Title: A study of communication within two Community Mental Health Teams (CMHTs)

Invitation to take part in the interview stage of the study

Thank you for your participation in the earlier stages of this study. I would now like to invite you to take part in a research interview. Before you decide I would like to explain what participating in an interview would involve for you. Please ask me if there is anything that is not clear, and feel free to contact me via the telephone number or email address provided below if you would like more information.

What is the research about?

The mental health field is rapidly changing with a number of recent reforms to services including the promotion of recovery, increased service user involvement, changing professional roles and greater performance management. The aim of this study is to develop knowledge of the way in which mental health care and support is provided in this new context. In particular, the study will examine how this restructuring of the mental health field impacts on the various ways of understanding mental illness and distress utilised by practitioners, service users and carers, and how these perspectives are expressed and negotiated within teams. The study will seek to provide an insight into the realities of inter-professional working and to give expression to the skills, complexity and challenges of frontline mental health practice. This research is primarily for educational purposes. The findings will be written up as a PhD thesis at the University of Birmingham.

Why have I been invited to take part?

In order to understand these processes better I would like to interview a cross-section of practitioners from across the professions working in the two CMHTs involved in the study. I intend to invite approximately 20 practitioners, 10 service users and 5 carers to participate in interviews.

Do I have to take part?

Participation in interviews and in the study is entirely voluntary, and you may withdraw at any time.

How will the interviews be carried out?

The interview will last for approximately one hour and will take place in your preferred setting, which could be either the office or another agreed location. I will ask you about your experiences of working in mental health services and understandings of mental illness and distress. I would like to include a detailed discussion of your work

with service users, how you came to an understanding of their mental health difficulties, and about how understandings of their mental health needs are negotiated in joint working. I would also like to discuss the way in which services and professional roles are changing. This will include the impact of changes such as recording information on RiO, care clustering using Honos PbR, and the introduction of CTOs and personalisation (Better Care Choices). I am interested in whether these have affected the way that you come to an understanding of the mental health difficulties of people using the service.

I would like to audio-record this so I do not miss important details. I will later type up notes of the interview and these, along with the notes of my observations from the first stage of the research, will be analysed to produce the research findings.

What are the possible disadvantages or risks of taking part?

Although this is not anticipated, if you do experience discomfort or distress at any time during the interview please let me know and feel free to move on from the difficult topic or stop the interview. As a former mental health practitioner I will aim to be as sensitive to these issues as possible.

What are the possible benefits of taking part?

Although there may not be any direct personal benefits from taking part in the study, the research aims to improve our understanding of inter-professional and practitioner-service user interaction and negotiation, so it is hoped that this will contribute to the development of more effective services. I also hope that you will find the opportunity to discuss and share your knowledge about mental health and services to be a positive experience.

What if there is a problem?

If you have any concerns about the conduct of the research or wish to make a complaint, please contact the administrator at the Institute of Applied Social Studies, University of Birmingham on [REDACTED] who will forward your concerns to the Institute management.

Will my taking part in this study be kept confidential?

All information which is collected during the course of the research will be kept strictly confidential, and all recorded information will have names removed so that individuals cannot be recognised. Data collected will be anonymised and stored on a password-protected computer in accordance with the Data Protection Act 1998. As principal researcher, I will be the only person with access to this data. The limits of confidentiality appropriate to professional practice will apply, and I have a legal obligation to disclose information relating to unethical or criminal behaviour.

What will happen after the research is complete?

I will write up the findings as a PhD thesis, and would be willing to provide a presentation to the team. I eventually hope to publish the findings to inform debate about contemporary mental health service provision and policy/practice development.

Who is organising and funding the research?

I have developed this study with support from the Centre of Excellence in Interdisciplinary Mental Health. The Economic and Social Research Council (ESRC) provide me with a student bursary, which is the only funding for the study. XXXXXXXX is supportive of the project, but the research is formally independent of the Trust.

Who has reviewed the study?

This study has been reviewed and given a favourable opinion by the XXXXXXXX Research Ethics Committee.

Contact details

If you require further information about the study or whether to participate, please feel free to contact me. My email address is [REDACTED], or you can call me at the University of Birmingham on [REDACTED]. Please leave a message and I will return your call as soon as possible. Further information about the Centre of Excellence in Interdisciplinary Mental Health at the University of Birmingham is available from www.ceimh.bham.ac.uk.

Thanks for your assistance.

Richard Moth
University of Birmingham

APPENDIX 1H: INFORMATION SHEET FOR SOUTHVILLE CMHT SERVICE USERS AND CARER INTERVIEWS

NHS Trust Logo

Participant Information Sheet for Service User and Carer Interviews

Title: A study of communication within two Community Mental Health Teams (CMHTs)

Invitation to take part in the interview stage of the study

Thank you for your participation in the earlier stages of this study. I would now like to invite you to take part in a research interview. Before you decide I would like to explain what participating in an interview would involve for you. Please take the time to read the following information carefully, and ask me if there is anything that is not clear or if you would like more information. I have used the term 'participant' to refer to people who agree to take part in the study.

Who is doing this research?

I am a researcher based at the Centre of Excellence in Interdisciplinary Mental Health, which is part of the Institute of Applied Social Studies at the University of Birmingham (ceimh.bham.ac.uk). I also have experience of working as a practitioner within XXXXXX.

What is the research about?

The way mental health services are organised is changing with a number of recent reforms. These include more emphasis on recovery, user involvement and setting targets for services alongside changes to the tasks that the different professions carry out. This study will look at the impact of these reforms on the way mental health practitioners work with service users and carers, and in particular on the way they understand mental illness and distress.

This research is primarily for educational purposes. The findings will be written up as a PhD thesis at the University of Birmingham.

Why have I been invited to take part?

In order to understand these processes better I would like to interview a cross-section of service users and carers linked to the two teams involved in the study. I intend to invite approximately 10 service users and 5 carers (as well as 20 practitioners) to participate in interviews.

Do I have to take part?

The choice of whether or not you wish to take part is entirely yours. I will go through this information sheet, which I will then give to you, and explain the interview process. If you agree to take part I will arrange with you a convenient time to meet to conduct the interview. However, if you don't wish to take part your service would not be affected in any way. Also, if you do agree to take part and then change your mind

you can opt out at any time without giving a reason.

How will interviews be carried out?

I will meet with you for about one hour at your preferred location, which could be in your home, at the CMHT office, or another agreed location. I will ask you to describe your understandings of your mental health needs, or those of the person you care for, and your experiences of using mental health services. I would like to audio-record our meeting so I do not miss any important details. I will later type up notes of the interview and these, along with the notes of our other meetings, will be analysed to produce the research findings.

Will I be paid for participating in the research?

In order to compensate you for your time and for any inconvenience involved in participating in the interview there will be a payment of £15.00.

What are the possible disadvantages or risks of taking part?

It is possible that you may feel some distress during the interview when discussing your mental health needs or those of the person for whom you provide care. If you do experience discomfort at any time please let me know and feel free to move on from the difficult topic or stop the interview. As a former mental health practitioner I will aim to be as sensitive to these issues as possible. However if extra support would be helpful after the interview it may be appropriate to contact your mental health worker.

What are the possible benefits of taking part?

Although there may not be any direct personal benefits from taking part in the study, the research aims to develop knowledge around what affects communication between mental health workers, service users and carers and in particular how mental health needs are understood. It is hoped that this will contribute to the development of more effective services. I also hope that you will find the opportunity to discuss and share your knowledge about mental health needs and services to be a positive experience.

What if there is a problem?

If you have any concerns about how this research is being carried out, or wish to make a complaint, please contact the administrator at the Institute of Applied Social Studies at the University of Birmingham on [REDACTED]. They will inform the Institute management who will contact you to discuss these issues.

Will taking part in this study be kept confidential?

Your name and details will not appear in the research report. All recorded information will have names removed so that individuals cannot be recognised. Data collected will be anonymised and stored on a password-protected computer in accordance with the Data Protection Act 1998. As principal researcher, I will be the only person with access to this data. Everything you say will be treated in the strictest confidence. The only exceptions are circumstances where I would be legally obliged to disclose information to the relevant authorities, or where you or someone else is in immediate danger of serious harm in which case I would need to inform someone who might be able to help.

What will happen after the research is complete?

I will provide a summary of the findings of the study in writing if you would like this. I will also report the findings in a PhD thesis, which I eventually hope to publish in journal or book form.

Who is organising and funding the research?

I have developed this study with support from the Centre of Excellence in Interdisciplinary Mental Health. The Economic and Social Research Council (ESRC) provide me with a student bursary, which is the only funding for the study. XXXXXX is supportive of the project, but the research is formally independent of the Trust.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by the XXXXXXXX Research Ethics Committee.

Contact details

If you require further information about the study or whether to participate, please feel free to contact me. If you have any questions I can come along with your worker to answer them, or you can call me at the University of Birmingham on [REDACTED]. Please leave a message and I will return your call as soon as possible. Further information about the Centre of Excellence in Interdisciplinary Mental Health is available from www.ceimh.bham.ac.uk.

Thanks for considering this request.

Richard Moth
University of Birmingham

APPENDIX 1J: INTERVIEW SCHEDULES

FOR PRACTITIONERS

1. BACKGROUND

(i) Professional context

- What is your professional background? Job title? How long have you been in this post?
- How long have you been a mental health practitioner? What was your route into this line of work? What was influential in your choice of profession?

(ii) Practice context

[I will name a service user to whom I was introduced by the practitioner in order to make this discussion more concrete]

- Could you describe in detail your work with [service user name]

2. MODELS

(i) Theoretical knowledge

- Which factors have contributed to or caused [service user]'s mental health difficulties? What do you call these difficulties?
- What are the best forms of help or treatment for [service user]'s mental health difficulties? Are these forms of help and treatment available to [service user]? What is it important to know in choosing which types of help or treatment to recommend?
- What should be the respective roles of [service user], you and the team, and the wider society when it comes to addressing [service user]'s mental health difficulties? Who should do what? [Prompt: who should have which roles and responsibilities?]
- If you had to sum it up, how would you describe your approach to work with [service user]? Have there been any particular dilemmas or challenges in this process?

- How have your training, professional or personal experiences or other factors informed your ways of understanding the nature of mental health difficulties?

(ii) Situated knowledge

- I have heard practitioners use the following terms, and wonder what these mean to you? Examples?
 - 'illness'
 - 'chronic'
 - 'acute'
 - 'in crisis/unwell'
 - 'stable'
 - 'recovery'

3. NEGOTIATING DIFFERENCES

- Are your understandings of the nature of service users' mental health needs ever different from those of your colleagues? Are your understandings ever different from those of the service user or carer?
- What is the effect if any of these differences?
- If there are differences, how might these be expressed, negotiated or resolved in the decision-making process? Examples?
- Are all ways of understanding mental health issues given equal weight or are some more prevalent than others? If so, why?

4. CHANGING SERVICE CONTEXT

- Do you think the relationship between the different practitioner groups is changing? Are professionals becoming more similar in their roles?
 - If yes, what perspectives may be lost to the team as a whole as a result of this convergence?
 - Do some of the differences go unsaid - for instance how you feel about the prominence of social inclusion (employment, housing, recovery), or

the prominence of medication issues and compliance?

- Has the introduction of the Service Line Management clustering process and the Honos PbR assessment tool affected how you understand the mental health difficulties of service users you work with? What are the effects on how services understand the mental health difficulties of service users?
- Does the emphasis on data management using RiO, and targets and PIs have any impact on the way you approach the mental health needs of service users? Please give examples.
- Does the focus on risk management or CTOs have any impact on the way you approach the mental health needs of service users? Please give examples.
- Does an increased focus on the 'choice' agenda, direct payments and personalisation have any impact on the way you approach the mental health needs of service users? Please give examples.
- What do you think the effect of changing roles such as nurse prescribing and AMHP will be? What, if any, impacts might there be on how professionals understand the mental health needs of service users?

5. OUTCOMES

- Do different approaches to the understanding of mental health needs ultimately lead to different outcomes for clients? Please give examples.

6. CONCLUDING QUESTIONS

- Would you like to say anything else about these topics? Do you have any questions about the interview/research that you would like to ask me? What sort of feedback from or further involvement with this study would be useful to you and/or the team?
- Would you please tell me your:
 - Ethnicity
 - Age

FOR SERVICE USERS

1. BACKGROUND

- How long have you been a user of services with the CMHT? How did you come to use the CMHT service?

2. MODELS

- Which factors have contributed to or caused your mental health difficulties? What do you call these difficulties?
- What are the best forms of help or treatment for your mental health difficulties? Are these forms of help and treatment available to you? What is it important to know when choosing from types of help or treatment?
- What should be the respective roles for you, your mental health workers, and the wider society when it comes to addressing your mental health difficulties? Who should do what? [Prompt: who should have which roles and responsibilities?]
- If you had to sum it up, how would you describe the work you have done with [practitioner]? Have there been any particular dilemmas or challenges in this process?
- What has informed your ways of understanding your mental health difficulties (personal experiences/other factors)? How has this changed over time?

3. NEGOTIATING DIFFERENCES

[I will ask the service user to think about their work with their care co-ordinator/psychiatrist in order to make this discussion more concrete]

- Are your understandings of the nature of your mental health difficulties ever different from those of the mental health practitioners working with you?
- What is the effect, if any, of these differences?
- If there are differences, how are these expressed, negotiated or resolved in the decision-making process? Examples?

- Are your understandings ever different from your carer? What is the effect, if any, of these differences?

4. CHANGING SERVICE CONTEXT

- Which ways of understanding mental health difficulties are most prominent in mental health services?
- What has been the effect of recent changes in practitioner roles and the way mental health services are organised?
- What has been the impact of making services more oriented to the idea of recovery?

5. OUTCOMES

- Have the different approaches to understanding mental health difficulties of the various practitioner groups ever affected the service you received?
- Which approaches worked for you? Which didn't work?
- What was the end result of this for you?

6. CONCLUDING QUESTIONS

- Would you like to say anything else about these topics? Do you have any questions about the interview/research that you would like to ask me?
What sort of feedback from or further involvement with this study would be useful to you?
- Would you please tell me your:
 - Ethnicity
 - Age

FOR CARERS

1. BACKGROUND

- How long have you been a carer? How long has the person you provide care for been a user of services with the CMHT? How did you and the person you provide care for come to use the CMHT service?

2. MODELS

- Which factors have contributed to or caused [person cared for]'s mental health difficulties? What do you call these difficulties?
- What are the best forms of help or treatment for [person cared for]'s mental health difficulties? Are these forms of help and treatment available? What is it important to know when choosing from types of help or treatment?
- What should be the respective roles for you and [person cared for], the mental health worker(s), and the wider society when it comes to addressing [person cared for]'s mental health difficulties? Who should do what? [Prompt: who should have which roles and responsibilities?]
- If you had to sum it up, how would you describe the work with [practitioner] and [person cared for]? Have there been any particular dilemmas or challenges in this process?
- What has informed your ways of understanding mental health difficulties (personal experiences/carers experience/other factors)? How has this changed over time?

3. NEGOTIATING DIFFERENCES

[I will ask the carer to think about their work with the care co-ordinator/ psychiatrist of the person for whom they provide care in order to make this discussion more concrete]

- Are your understandings of the nature of [service user]'s mental health difficulties ever different from those of the mental health practitioners working with you?
- What is the effect, if any, of these differences?
- If there are differences, how are these expressed, negotiated or resolved in

the decision-making process? Examples?

- Are your understandings ever different from [service user]'s? What is the effect, if any, of these differences?

4. CHANGING SERVICE CONTEXT

- Which ways of understanding mental health difficulties are most prominent in mental health services?
- Have recent changes in practitioner roles and the way mental health services are organised had any effect?
- What has been the impact of making services more oriented to the idea of recovery?

5. OUTCOMES

- Have the different approaches to understanding mental health difficulties of the various practitioner groups ever affected the service you received?
- Which approaches worked for you and the person for whom you provide care? Which didn't work?
- What was the end result of this for you?

6. CONCLUDING QUESTIONS

- Would you like to say anything else about these topics? Do you have any questions about the interview/research that you would like to ask me?
What sort of feedback from or further involvement with this study would be useful to you and/or the team?
- Would you please tell me your
 - Ethnicity
 - Age

APPENDIX 2A: FIELDNOTE DATA 2008 (NORTHVILLE CMHT)

| June 2008 | July 2008 | August 2008 |
|-----------|-----------|-------------|
| 25/06/08 | 01/07/08 | 01/08/08 |
| 26/06/08 | 02/07/08 | 06/08/08 |
| 27/06/08 | 03/07/08 | 08/08/08 |
| | 09/07/08 | 11/08/08 |
| | 10/07/08 | 12/08/08 |
| | 11/07/08 | 13/08/08 |
| | 23/07/08 | 15/08/08 |
| | 24/07/08 | |
| | 25/07/08 | |
| | 29/07/08 | |
| | 30/07/08 | |
| | 31/07/08 | |

APPENDIX 2B: FIELDNOTE DATA 2009-2010 (SOUTHVILLE CMHT)

| October 2009 | November 2009 | December 2009 | January 2010 | February 2010 | March 2010 | April 2010 | May 2010 | June 2010 | July 2010 | Nov/Dec 2010 |
|-----------------|------------------|------------------|-----------------|------------------|---------------|---------------|-------------|--------------|--------------|-----------------|
| 21/10/09 | 02/11/09 | 01/12/09 | 04/01/10 | 01/02/10 | 01/03/10 | 01/04/10 | 04/05/10 | 01/06/10 | 01/07/10 | 14/11/10 |
| 22/10/09 | 03/11/09 | 14/12/09 | 05/01/10 | 04/02/10 | 02/03/10 | 14/04/10 | 05/05/10 | 02/06/10 | 06/07/10 | 13/12/10 |
| 23/10/09 | 04/11/09 | 15/12/09 | 06/01/10 | 05/02/10 | 03/03/10 | 15/04/10 | 06/05/10 | 04/06/10 | | 22/12/10 |
| 26/10/09 | 05/11/09 | 16/12/09 | 07/01/10 | 08/02/10 | 04/03/10 | 16/04/10 | 07/05/10 | 07/06/10 | | |
| 27/10/09 | 06/11/09 | 17/12/09 | 08/01/10 | 09/02/10 | 05/03/10 | 19/04/10 | 11/05/10 | 09/06/10 | | |
| 28/10/09 | 09/11/09 | 21/12/09 | 13/01/10 | 10/02/10 | 10/03/10 | 20/04/10 | 12/05/10 | 10/06/10 | | |
| 29/10/09 | 10/11/09 | 22/12/09 | 14/01/10 | 11/02/10 | 15/03/10 | 21/04/10 | 13/05/10 | 15/06/10 | | |
| 30/10/09 | 11/11/09 | 23/12/09 | 18/01/10 | 12/02/10 | 17/03/10 | 22/04/10 | 17/05/10 | 16/06/10 | | |
| | 12/11/09 | | 19/01/10 | 16/02/10 | 22/03/10 | 23/04/10 | 20/05/10 | 17/06/10 | | |
| | 13/11/09 | | 20/01/10 | 23/02/10 | 23/03/10 | 26/04/10 | 21/05/10 | 18/06/10 | | |
| | 17/11/09 | | 21/01/10 | 24/02/10 | 24/03/10 | 27/04/10 | 24/05/10 | 21/06/10 | | |
| | 18/11/09 | | 22/01/10 | 25/02/10 | 25/03/10 | 28/04/10 | 26/05/10 | 22/06/10 | | |
| | 19/11/09 | | 25/01/10 | | 26/03/10 | 29/04/10 | 27/05/10 | 23/06/10 | | |
| | 20/11/09 | | 26/01/10 | | 31/03/10 | 30/04/10 | 28/05/10 | 24/06/10 | | |
| | 23/11/09 | | 27/01/10 | | | | | 25/06/10 | | |
| | 25/11/09 | | 28/01/10 | | | | | 28/06/10 | | |
| | 27/11/09 | | 29/01/10 | | | | | 29/06/10 | | |
| | | | | | | | | 30/06/10 | | |

APPENDIX 2C: FIELDNOTE DATA 2011 (SOUTHVILLE CMHT)

| January 2011 | February 2011 | March 2011 | April 2011 | May 2011 | June 2011 | July 2011 | August 2011 | September 2011 |
|----------------------|--|--|----------------------------------|--|--|--|--|----------------------|
| 05/01/11 19/01/11 | 02/02/11 03/02/11 04/02/11 09/02/11 10/02/11 18/02/11 23/02/11 24/02/11 25/02/11 | 01/03/11 09/03/11 10/03/11 11/03/11 16/03/11 23/03/11 24/03/11 25/03/11 28/03/11 30/03/11 | 01/04/11 04/04/11 05/04/11 | 04/05/11 05/05/11 11/05/11 12/05/11 13/05/11 16/05/11 17/05/11 18/05/11 25/05/11 | 01/06/11 06/06/11 07/06/11 08/06/11 21/06/11 22/06/11 | 25/07/11 26/07/11 27/07/11 28/07/11 29/07/11 | 01/08/11 02/08/11 03/08/11 04/08/11 05/08/11 08/08/11 09/08/11 | 20/09/11 21/09/11 |

APPENDIX 2D: CMHT APPOINTMENTS AND HOME VISITS

| Name | Gender | Date of Meeting | Location |
|----------------------|--------|------------------------------|---------------------------------|
| Service user 1 | Male | 19/11/09 | Southville CMHT |
| Ron (pseudonym) | Male | 19/11/09; 17/12/09; 25/02/10 | Southville CMHT |
| Jonny (pseudonym) | Male | 15/12/09 | Home visit (HV) |
| Service user 2 | Male | 15/12/09 | HV |
| Service user 3 | Female | 22/12/09; 04/01/10 | HV |
| Service user 4 | Male | 22/12/09 | HV |
| Service user 5 | Male | 05/01/10; 09/02/10 | Southville CMHT |
| Service user 6 | Female | 05/01/10; 20/05/10 | Southville CMHT |
| Service user 7 | Male | 21/01/10; 17/05/10; 28/05/10 | Southville CMHT |
| Service user 8 | Male | 21/01/10 | Southville CMHT |
| Service user 9 | Male | 26/01/10 | Southville CMHT |
| Alistair (pseudonym) | Male | 27/01/10 | Southville CMHT |
| Service user 10 | Male | 29/01/10; 25/02/10 | HV |
| Service user 11 | Male | 01/02/10 | HV |
| Service user 12 | Male | 11/02/10 | Southville CMHT |
| Service user 13 | Male | 23/02/10; 22/04/10; 28/06/10 | HV |
| Service user 14 | Male | 21/04/10 | Southville CMHT |
| Service user 15 | Male | 23/04/10 | HV |
| Service user 16 | Female | 30/04/10 | HV |
| Service user 17 | Male | 27/04/10 | Southville CMHT |
| Service user 18 | Male | 06/05/10 | HV |
| Service user 19 | Male | 27/05/10 | Middletown Mental Health Centre |
| Service user 20 | Male | 22/06/10 | HV |
| Service user 21 | Male | 22/06/10 | Southville CMHT |
| Service user 22 | Male | 24/06/10 | Southville CMHT |
| Service user 23 | Female | 23/02/11 | Southville CMHT |

APPENDIX 2E: WARD ROUND DATA (UPTON WARD, MIDDLETOWN MENTAL HEALTH CENTRE)

| Date | Service user | Gender |
|----------|------------------|--------|
| 26/04/10 | Service user 24 | Male |
| 26/04/10 | Service user 7 | Male |
| 17/05/10 | Service user 24 | Male |
| 17/05/10 | Manu (pseudonym) | Male |
| 17/05/10 | Service user 25 | Male |
| 24/05/10 | Service user 25 | Male |
| 24/05/10 | Service user 14 | Male |
| 24/05/10 | Manu (pseudonym) | Male |
| 07/06/10 | Manu (pseudonym) | Male |
| 07/06/10 | Service user 14 | Male |
| 21/06/10 | Manu (pseudonym) | Male |
| 21/06/10 | Service user 7 | Male |

APPENDIX 2F: INTERVIEW DATA (STAFF)

| Name ¹ /ID | Gender | Role | Interview Date | Location |
|-----------------------|--------|--------------------------------------|--------------------|-----------------|
| Ruth | Female | Social Worker | 23/02/11 | Southville CMHT |
| 4WEL | Male | Welfare rights | 09/03/11 | Southville CMHT |
| Roger | Male | Community Mental Health Nurse (CMHN) | 10/03/11; 28/03/11 | Southville CMHT |
| Kath | Female | CMHN | 10/03/11 | Southville CMHT |
| Kerry | Female | Occupational Therapist | 11/03/11; 25/03/11 | Southville CMHT |
| Mohinder | Male | ST5 Psychiatrist | 23/03/11; 01/06/11 | Southville CMHT |
| Eve | Female | CMHN/Team Manager | 01/04/11; 13/05/11 | Southville CMHT |
| Farooq | Male | Social Worker | 04/05/11 | Southville CMHT |
| 11SWS | Female | Student Social Worker | 05/05/11 | Southville CMHT |
| Phil | Male | CMHN | 12/05/11 | Southville CMHT |
| Leslie | Male | CMHN | 12/05/11; 25/05/11 | Southville CMHT |
| 14AD | Male | Administrator | 16/05/11 | Southville CMHT |
| Bill | Male | CMHN | 17/05/11 | Southville CMHT |
| Abbie | Female | CMHN | 17/05/11; 06/06/11 | Southville CMHT |
| Filipe | Male | Social Worker/Assistant Manager | 18/05/11; 22/06/11 | Southville CMHT |
| Yvonne | Female | Social Worker | 06/06/11 | Southville CMHT |
| Constance | Female | Social Worker | 08/06/11 | Southville CMHT |
| Dr James Byrant | Male | Consultant Psychiatrist | 21/06/11; 28/07/11 | Southville CMHT |
| 21AD | Female | Administrator | 03/08/11 | Southville CMHT |
| 22PSYC | Male | Consultant Psychiatrist | 20/09/11 | Northville CMHT |
| 23CP | Male | Clinical Psychologist | 21/09/11 | Northville CMHT |

¹ All names are pseudonyms

APPENDIX 2G: INTERVIEW DATA (SERVICE USERS AND CARERS)

| Name | Gender | Date | Location |
|------------------------------------|--------|----------|------------------------------|
| Felicity (Carer, pseudonym) | Female | 21/07/11 | Southville CMHT |
| Service user 3 | Female | 27/07/11 | Home |
| Carer 1 | Female | 28/07/11 | Home |
| Service user 13 | Male | 28/07/11 | Carers home |
| Service user 11 | Male | 29/07/11 | Home |
| Carer 2 | Female | 29/07/11 | Home |
| Alistair (Service user, pseudonym) | Male | 03/08/11 | Southville CMHT |
| Service user 10 | Male | 05/08/11 | Home |
| Jonny (service user, pseudonym) | Male | 08/08/11 | Home |
| Service user 23 | Female | 09/08/11 | Midlake Mental Health Centre |
| Service user 21 | Male | 21/09/11 | Home |

APPENDIX 2H: CASE RECORDS & OTHER DOCUMENTS

| Name | Document |
|----------------------|--|
| Alistair (pseudonym) | RiO Notes GP Letter 1 28/09/09 GP Letter 2 21/10/09 GP Letter 3 09/12/09 Employer Letter 4 12/01/11 Occupational Health Letter 12/01/11 GP Letter 5 01/02/11 Admissions Summary 31/07/09 Risk Assessment 11/09/09 Progress Notes 27/01/10 Progress Notes 03/12/10 Progress Notes 07/02/11 Progress Notes 30/03/11 Progress Notes 13/07/11 |
| Jonny (pseudonym) | Care Plan 08/03/11 Care Programme Approach Form 15/03/07 Care Programme Approach Form 08/03/11 GP Letter 08/03/11 Placement Review 17/01/08 Progress Notes 15/12/09 Risk Assessment 13/04/06 |
| Service user 3 | Care Plan 01/03/10 Progress Notes 03/12/09 Risk Assessment 23/10/09 Care Programme Approach Form 26/11/09 Occupational Therapist Letter 09/11/09 |
| Service user 7 | Discharge Summary 29/04/10 Discharge Summary 20/07/10 Admissions Summary 28/05/10 AMHP Report 28/05/10 Care Plan 21/01/10 Care Plan 21/06/10 Core Assessment 19/04/10 Progress Notes 17/05/10 Progress Notes 26/04/10 Risk Summary 14/05/10 |
| Service user 10 | Benefits Letter 14/01/11 Clinic Letter 14/01/11 Progress Notes 17/03/10 |
| Service user 11 | Clinic Letter 02/11/10 Care Programme Approach Form 07/05/08 Care Programme Approach Form 08/12/09 GP Letter 15/03/10 Risk Assessment 16/11/10 |

| | |
|-----------------|---|
| Service user 13 | Admissions Summary 24/11/09 Care Plan 21/12/09 Carer Assessment 19/03/10 Core Assessment 15/01/10 Care Programme Approach Form 23/07/10 DWP Letter 22/02/10 Discharge Summary 21/12/09 Progress Notes 08/02/10 Risk Assessment 26/10/09 |
| Service user 14 | Care Plan 03/11/10 Core Assessment 28/10/09 Care Plan 01/06/10 Forensic Report 28/05/10 Risk Assessment 2007 Progress Notes 14/07/10 Progress Notes 07/06/10 Occupational Therapist Report 02/07/10 Discharge Summary 17/08/10 |
| Other documents | CMHT Report 2006 Untrustworthy Newsletter Article on Interprofessionalism & Resistance |

APPENDIX 3: RECONSTRUCTED PENTIMENTO DIAGRAM

